Exhibit A

HEALTHY OPTIONS PROVISIONS

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1 PAYMENT

1.1 Monthly Premium Payment Calculation

The monthly premium payment for each enrollee will be calculated as follows:

Premium Payment = Statewide Base Rate X Age/Sex Adjustment Factor X Risk Adjustment Factor X Geographical Adjustment Factor X Quality Adjustment Factor

1.1.1 Through December 31, 2013, the Geographical Adjustment Factors will be those that result from the Request for Proposal that resulted in this Contract. Thereafter the Geographical Adjustment Factors will be recalculated by the Health Care Authority (HCA) annually to reflect changes in the relative cost of providing care in different geographical areas of the State. The Geographical Adjustment Factor is the same for all contractors in a service area.

1.1.2 Through December 31, 2012, the Risk Adjustment Factor will be as stated in the Request for Proposal that resulted in this Contract. Thereafter Risk Adjustment Factors will be recalculated by the Health Care Authority periodically, at the Health Care Authority's sole discretion, to reflect changes in the relative health status of the populations enrolled with the contractors. The Risk Adjustment Factors are calculated by geographical region and by contractor.

1.1.3 Through December 31, 2013, the Quality Adjustment Factor will be based on the Health Care Authority's scoring of the Contractor's response to the Request for Proposals that resulted in this Contract.. The calculation of the Quality Adjustment Factor will be as stated in that Request for Proposals. Thereafter the Health Care Authority will calculate the Quality Adjustment Factor based upon outcome measures selected by the Health Care Authority.

1.1.4 The Health Care Authority shall automatically generate newborn premiums whenever possible. For newborns whose premiums the Health Care Authority does not automatically generate, the Contractor shall submit a premium payment request to the Health Care Authority within 365 calendar days of the date of birth. The Health Care Authority shall pay premiums through the end of the month in which the twenty-first (21st) day of life occurs.

1.1.5 The Health Care Authority shall make a full monthly payment to the Contractor for the month in which an enrollee's enrollment is terminated except as otherwise provided herein.

1.1.6 The Contractor shall be responsible for contracted services provided to the enrollee in any month for which the Health Care Authority paid the Contractor for the enrollee's care under the terms of this Contract.

1.2 Delivery Case Rate Payment

A one-time payment shall be made to the Contractor for labor and delivery expenses for enrollees enrolled with the Contractor during the month of delivery. The Delivery Case Rate shall only be paid to the Contractor if the Contractor has incurred and paid direct costs for labor and delivery based on encounter data received by Health Care Authority. Delivery includes both live and stillbirths, but does not include miscarriage, induced abortion, or other fetal demise not requiring labor and delivery to terminate the pregnancy.

1.3 Recoupments

Unless mutually agreed by the parties in writing, the Health Care Authority shall only recoup premium payments and retroactively terminate enrollment for individual enrollees:

1.3.1 With duplicate coverage.

1.3.2 Deceased prior to the month of enrollment. Premium payments shall be recouped effective the first day of the month following the enrollee's date of death.

1.3.3 Retroactively have their enrollment terminated consistent with the this Contract.

1.3.4 Found ineligible for enrollment with the Contractor, provided the Health Care Authority has notified the Contractor before the first day of the month for which the premium was paid.

1.3.5 An inmate at a correctional facility in any full month of enrollment.

1.3.6 When an audit determines that payment was made in error.

1.3.7 The Contractor may recoup payments made to providers for services provided to enrollees during the period for which the Health Care Authority recoups premiums for those enrollees. If the Contractor recoups said payments, providers may submit appropriate claims for payment to the Health Care Authority through its fee-for-service program.

1.3.8 When the Health Care Authority recoups premiums and retroactively terminates the enrollment of an enrollee, the Health Care Authority will not recoup premiums and retroactively terminate the enrollment of any other family member, except for newborns whose mother's enrollment is terminated for duplicate coverage.

1.4 Stop Loss for Hemophiliac Drugs

The Health Care Authority will provide stop loss protection for the Contractor for paid claims for Factors VII, VIII and IX and the anti-inhibitor for enrollees with a diagnosis of hemophilia as identified by diagnosis codes 286.0-286.3, V83.01 and V83.02. The Health Care Authority will reimburse the Contractor seventy-five

percent (75%) of all verifiable paid claims for the identified hemophiliac drugs in excess of $250,000 for any single enrollee enrolled with the Contractor during each contract year. The Contractor must submit documentation of paid claims as required by the Health Care Authority.

1.5 Encounter Data

The Contractor shall comply with the required format and reporting timeline provided in the Encounter Data Reporting Guide published by the Health Care Authority . Encounter data includes claims processed by the Contractor for services delivered to enrollees through the Contractor. The Health Care Authority collects and uses this data for many reasons such as: federal reporting (42 CFR 438.242(b)(1)); rate setting and risk adjustment; service verification, managed care quality improvement program, utilization patterns and access to care; the Health Care Authority hospital rate setting; and research studies. The Health Care Authority may change the Encounter Data Reporting Guide with one hundred and fifty (150) calendar days' written notice to the Contractor. The Encounter Data Reporting Guide may be changed with less than one hundred and fifty (150) calendar days' notice by mutual agreement of the Contractor and the Health Care Authority. The Contractor shall, upon receipt of such notice from the Health Care Authority, provide notice of changes to subcontractors.

1.6 Retroactive Premium Payments for Enrollee Categorical Changes

Enrollees may have retroactive changes in their elgibility category. Such changes will only affect premium payments prospectively.

1.7 Provider Payment Reform

HCA intends to reform provider payment. The Contractor shall collaborate and cooperate with HCA on provider payment reform. The Contractor will provide in a timely manner any information necessary to support HCA's analyses of provider payment.

2 ENROLLMENT

2.1 Service Areas

The Contractor's policies and procedures related to Enrollment shall ensure compliance with the requirements described in this section.

2.1.1 The Contractor's service areas are described in Exhibit C,. The Health Care Authority may modify Exhibit C, for service area changes as described in this Section.

2.1.2 Clients in the eligibility groups described in this Section are eligible to enroll with the Contractor if they reside in the Contractor's service areas.

2.2 Service Area Changes

2.2.1 With the written approval of the Health Care Authority, the Contractor may expand into additional service areas at any time by giving written notice to

the Health Care Authority, along with evidence, as the Health Care Authority may require, demonstrating the Contractor's ability to support the expansion.

2.2.1.1 The Health Care Authority may withhold approval of a requested expansion, if, in the Health Care Authority's sole judgment, the requested expansion is not in the best interest of the Health Care Authority.

2.2.1.2 If approved, the timing of the expansion will be at the Health Care Authority's sole discretion.

2.2.1.3 The Contractor may not decrease service areas except during Contract renewal, i.e., when the Contract is extended as provided herein.

2.2.2 If the U.S. Postal Service alters the zip code numbers or zip code boundaries within the Contractor's service areas, the Health Care Authority shall alter the service area zip code numbers or the boundaries of the service areas with input from the affected contractors.

2.2.3 The Health Care Authority shall determine, in its sole judgment, which zip codes fall within each service area.

2.2.4 The Health Care Authority will use the enrollee's residential zip code to determine whether an enrollee resides within a service area.

2.3 Eligible Client Groups

The Health Care Authority shall determine eligibility for enrollment under this Contract. The Health Care Authority will provide the Contractor a list of Recipient Aid Categories (RACs) that are eligible to enroll in Healthy Options. The HCA will also provide the Contractor with a list of Basic Health applicants and enrollees who are eligible for enrollment with the Contractor under Basic Health Plus or the Maternity Benefits Program. For the purposes of this Contract, "HO Contractor", "enrollee" and "HO plan" also apply to Basic Health Plus and Maternity Benefit Program. Clients in the following eligibility groups at the time of enrollment are eligible for enrollment under this Contract.

2.3.1 Clients receiving Medicaid under Social Security Act (SSA) provisions for coverage of families receiving Temporary Assistance for Needy Families and clients who are not eligible for cash assistance who remain eligible for medical services under Medicaid.

2.3.2 Children, from birth through eighteen (18) years of age, eligible for Medicaid under expanded pediatric coverage provisions of the Social Security Act.

2.3.3 Pregnant Women, eligible for Medicaid under expanded maternity coverage provisions of the Social Security Act.

2.3.4 Children eligible for the Children's Health Insurance Program (CHIP).

2.3.5 Categorically Needy - Blind and Disabled Children and Adults who are not eligible for Medicare.

2.3.6 Children in Foster Care may enroll voluntarily.

2.4 Client Notification

The Health Care Authority shall notify eligible clients of their rights and responsibilities as Healthy Options (HO) enrollees at the time of initial eligibility determination, after a break in eligibility greater than 12 months or at least annually.

2.5 Exemption from Enrollment

A client may request exemption from enrollment. Each request for exemption will be reviewed by the Health Care Authority pursuant to WAC 182-538 or WAC 182-542. When the client is already enrolled with the Contractor and wishes to be exempted, the exemption request will be treated as a termination of enrollment request consistent with the Termination of Enrollment provisions of this Section.

2.6 Enrollment Period

Subject to the Effective Date of Enrollment provisions of this Section, enrollment is continuously open. Enrollees shall have the right to change enrollment prospectively, from one HO plan to another without cause, each month except as described in the Patient Review and Coordination (PRC) provisions of this Contract.

2.7 Enrollment Process

2.7.1 The Health Care Authority will assign the client, and all eligible family members, to the same HO contractor in accord with the Assignment of Enrollees provisions of this Contract.

2.7.2 The client, the client's representative or responsible parent or guardian must notify the Health Care Authority if they want to choose another health plan.

2.7.3 The Health Care Authority will attempt to enroll all family members with the same HO plan unless the following occurs:

2.7.3.1 A family member is placed into the Patient Review and Coordination (PRC) program by the Contractor or the Health Care Authority. The PRC placed family member shall follow the enrollment requirements described in the PRC provisions of this Contract. The remaining family members shall be enrolled with a single, HO plan of their choice.

2.7.3.2 The Health Care Authority grants an exception because the family members have conflicting medical needs that cannot be met by a single HO contractor.

2.8 Effective Date of Enrollment

Except for a newborn whose mother is enrolled in a HO plan, enrollment with the Contractor shall be effective on the later of the following dates:

2.8.1 If the enrollment is processed on or before the the Health Care Authority cut-off date for enrollment, enrollment shall be effective the first day of the month following the month in which the enrollment is processed; or

2.8.2 If the enrollment is processed after the the Health Care Authority cut-off date for enrollment, enrollment shall be effective the first day of the second month following the month in which the enrollment is processed.

2.9 Newborns Effective Date of Enrollment

Newborns whose mothers are enrollees on the date of birth shall be deemed enrollees and enrolled in the same plan as the mother as follows:

2.9.1 Retrospectively for the month(s) in which the first 21 days of life occur and prospectively, beginning the first of the month after the newborn is reported to the Health Care Authority.

2.9.2 If the newborn does not receive a separate client identifier from the Health Care Authority the newborn enrollment will be only available through the end of the month in which the first 21 Days of life occur.

2.9.3 If the mother’s enrollment is ended before the newborn receives a separate client identifier from the Health Care Authority, the newborn's enrollment shall end the last day of the month in which the 21st day of life occurs or when the mother's enrollment ends, whichever is later, except as provided in the provisions of the Enrollee Hospitalized at Termination of Enrollment of the Benefits Section of this Contract.

2.9.3.1 Adopted children shall be covered consistent with the provisions of Title 48 RCW.

2.9.3.2 No retroactive coverage is provided under this Contract, except as described in this section or by mutual agreement by both parties to this Contract.

2.10 Enrollment Data and Re uirements for Contractor's Response

The Health Care Authority will provide the Contractor with data files with the information needed to perform the services described in this Contract.

2.10.1 Data files will be sent to the Contractor at intervals specified within the Health Care Authority 834 Benefit Enrollment and Maintenance Companion Guide, published by the Health Care Authority and incorporated by reference.

2.10.2 The data file will be in the Health Insurance Portability and Accountability Act (HIPAA) compliant 834, Benefit Enrollment and Maintenance format (45 CFR 162.1503).

2.10.3 The data file will be transferred per specifications defined within the Health Care Authority Companion Guides.

2.10.4 The Contractor shall have ten (10) calendar days from the receipt of the data files to notify the Health Care Authority in writing of the refusal of an application for enrollment or any discrepancy regarding the Health Care Authority' proposed enrollment effective date. Written notice shall include the reason for refusal and must be agreed to by the Health Care Authority. The effective date of enrollment specified by the Health Care Authority shall be considered accepted by the Contractor and shall be binding if the notice is not timely or the Health Care Authority does not agree with the reasons stated in the notice. Subject to the Health Care Authority approval, the Contractor may refuse to accept an enrollee for the following reasons:

2.10.4.1 The Health Care Authority has enrolled the enrollee with the Contractor in a service area the Contractor is not contracted for.

2.10.4.2 The enrollee is not eligible for enrollment under the terms of this Contract.

2.11 Termination of Enrollment

2.11.1 Voluntary Termination of Enrollment

2.11.1.1 Enrollees may request termination of enrollment by submitting a written request to terminate enrollment to the Health Care Authority or by calling the the Health Care Authority toll-free enrollment number (42 CFR 438.56(d)(1)(i)). Except as provided in WAC 182-538 or WAC 388-542, the enrollment for enrollees whose enrollment is terminated will be prospectively ended. The Contractor may not request voluntary termination of enrollment on behalf of an enrollee.

2.11.2 Involuntary Termination of Enrollment Initiated by the Health Care Authority for Ineligibility

2.11.2.1 The enrollment of any enrollee under this Contract shall be terminated if the enrollee becomes ineligible for enrollment due to a change in eligibility status.

2.11.3 When an enrollee's enrollment is terminated for ineligibility, the termination shall be effective:

2.11.3.1 The first day of the month following the month in which the enrollment termination is processed by the Health Care Authority

if it is processed on or before the the Health Care Authority cut-off date for enrollment or the Contractor is informed by the Health Care Authority of the enrollment termination prior to the first day of the month following the month in which it is processed by the Health Care Authority.

2.11.3.2 Effective the first day of the second month following the month in which the enrollment termination is processed if it is processed after the the Health Care Authority cut-off date for enrollment and the Contractor is not informed by the Health Care Authority of the enrollment termination prior to the first day of the month following the month in which it is processed by the Health Care Authority.

2.11.4 Newborns placed in foster care prior to discharge from their initial birth hospitalization shall have their enrollment terminated effective their date of birth.

2.11.5 Involuntary Enrollment Termination Initiated by the Health Care Authority for Comparable Coverage or Duplicate Coverage:

2.11.5.1 The Contractor shall notify the Health Care Authority, in accord with the Notices provision of the General Terms and Conditions Section of this Contract, when an enrollee has health care insurance coverage with the Contractor or any other carrier:

2.11.5.1.1 Within fifteen (15) working days when an enrollee is verified as having duplicate coverage with the Contractor, as defined herein.

2.11.5.1.2 Within fifteen (15) working days days of the date when the Contractor becomes aware that an enrollee has any health care insurance coverage with any other insurance carrier. The Contractor is not responsible for the determination of comparable coverage, as defined herein.

2.11.5.1.3 The Health Care Authority will involuntarily terminate the enrollment of any enrollee with duplicate coverage or comparable coverage as follows:

2.11.5.1.3.1 When the enrollee has duplicate coverage that has been verified by the Health Care Authority, the Health Care Authority shall terminate enrollment retroactively to the beginning of the month of duplicate coverage and recoup premiums as describe in the Recoupments provisions of the

Payment and Sanctions Section of this Contract.

2.11.5.1.3.2 When the enrollee has comparable coverage which has been verified by the Health Care Authority, the Health Care Authority shall terminate enrollment prospectively.

2.11.6 Involuntary Termination Initiated by the Contractor

2.11.6.1 To request involuntary termination of enrollment, the Contractor shall send written notice to the Health Care Authority as described in Notices provision of the General Terms and Conditions Section of this Contract.

2.11.6.1.1 The Health Care Authority shall review each involuntary termination request on a case-by-case basis. The Contractor shall be notified in writing of an approval or disapproval of the involuntary termination request within thirty (30) working days of the Health Care Authority' receipt of such notice and the documentation required to substantiate the request. The Health Care Authority shall approve the request for involuntarily termination of the enrollee when the Contractor has substantiated in writing all of the following (42 CFR 438.56(b)(1)):

2.11.6.1.1.1 The enrollee's behavior is inconsistent with the Contractor's policies and procedures addressing unacceptable enrollee behavior.

2.11.6.1.1.2 The Contractor has provided a clinically appropriate evaluation to determine whether there is a treatable condition contributing to the enrollee's behavior and such evaluation either finds no treatable condition to be contributing, or, after evaluation and treatment, the enrollee's behavior continues to prevent the provider from safely or prudently providing medical care to the enrollee.

2.11.6.1.1.3 The enrollee received written notice from the Contractor of its intent to request the enrollee's

termination of enrollment, unless the requirement for notification has been waived by the Health Care Authority because the enrollee's conduct presents the threat of imminent harm to others. The Contractor's notice to the enrollee shall include the enrollee's right to use the Contractor's grievance process to review the request to end the enrollee's enrollment.

2.11.6.2 The Contractor shall continue to provide services to the enrollee until the Health Care Authority has notified the Contractor in writing that enrollment is terminated.

2.11.6.3 The Health Care Authority will not terminate enrollment of an enrollee solely due to a request based on an adverse change in the enrollee's health status, the cost of meeting the enrollee's health care needs, because of the enrollee's utilization of medical services, uncooperative or disruptive behavior resulting from their special needs or treatable mental health condition (WAC 182-538-130 and 42 CFR 438.56(b)(2)).

2.11.7 An enrollee whose enrollment is terminated for any reason, other than incarceration, at any time during the month is entitled to receive contracted services, at the Contractor's expense, through the end of that month.

2.11.8 In no event will an enrollee be entitled to receive services and benefits under this Contract after the last day of the month in which their enrollment is terminated, except:

2.11.8.1 When the enrollee is hospitalized at termination of enrollment and continued payment is required in accord with the provisions of the Enrollee Hospitalized at Enrollment and Enrollee Hospitalized at Termination of Enrollment in the Benefits Section of this Contract.

2.11.8.2 For the provision of information and assistance to transition the enrollee’s care with another provider.

2.11.8.3 As necessary to satisfy the results of an appeal or hearing.

3 BENEFITS

3.1 Scope of Services

3.1.1 The Contractor is responsible for covering medically necessary services relating to (42 CFR 438.210(a)(4)):

3.1.1.1 The prevention, diagnosis, and treatment of health impairments.

3.1.1.2 The achievement of age-appropriate growth and development.

3.1.1.3 The attainment, maintenance, or regaining of functional capacity.

3.1.2 If a service is covered by the Health Care Authority under its fee-for-service program, that service is a contracted service, and shall be provided by the Contractor when medically necessary, including all specific procedures and elements, unless it is specifically excluded under this Contract. Covered services are described in the Health Care Authority' billing instructions, incorporated by reference.

3.1.3 For services that the Health Care Authority determines are non-covered or limited in its fee-for-service program, that are not specifically excluded by this Contract, excluded from coverage under Federal regulations or excluded from coverage by the Health Care Authority, the Contractor will have policies and procedures for Exception to Rule (ETR) and Limitation Extension (LE) that are equivalent to the procedures described in WAC 182-501-0160 and 182-501-0169. The Contractor is responsible for providing a service when the Contractor's ETR or LE results in approval of the service.

3.1.4 If the coverage of services is modified in the fee-for-service program, the modification will be effective for the Contractor on the same date as it is effective in the fee-for-service program.

3.1.5 The Health Care Authority makes all decisions about what is and is not a covered service in the Medicaid and CHIP programs, both for the fee-for-service program (FFS) and HO. This Contract does not in any manner delegate coverage decisions to the Contractor. The Contractor must provide the same amount, duration and scope of services as the Health Care Authority fee-for-service program unless a service is specifically excluded. Covered services that are not excluded are contracted services. The Contractor makes the decision whether or not a contracted service is medically necessary. Medical necessity decisions are to be made based on an individual enrollee's healthcare needs by a health care professional with expertise appropriate to the enrollee's condition. The Contractor may not make global medical necessity decisions, since that is a coverage decision. The Contractor is allowed to have guidelines, developed and overseen by appropriate health care professionals, for approving services. All denials of contracted services are to be individual medical necessity decisions made by a health care professional without being limited by such guidelines.

3.1.6 Except as otherwise specifically provided in this Contract, the Contractor shall provide contracted services in the amount, duration and scope described in the Medicaid State Plan (42 CFR 438.210(a)(1 & 2)).

3.1.7 The amount and duration of contracted services that are medically necessary depends on the enrollee's condition (42 CFR 438.210(a)(3)(i)).

3.1.8 The Contractor shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of the enrollee's diagnosis, type

of illness or condition (42 CFR 438.210(a)(3)(ii).

3.1.9 Except as specifically provided in the provisions of the Authorization of Services Section, the requirements of this Section shall not be construed to prevent the Contractor from establishing utilization control measures as it deems necessary to assure that services are appropriately utilized, provided that utilization control measures do not deny medically necessary contracted services to enrollees. The Contractor's utilization control measures are not required to be the same as those in the Medicaid fee-for-service program (42 CFR 438.210(a)(3)(iii).

3.1.10 For specific contracted services, the requirements of this Section shall also not be construed as requiring the Contractor to provide the specific items provided by the Health Care Authority under its fee-for-service program, but shall rather be construed to require the Contractor to provide the same scope of services.

3.1.11 Nothing in this Contract shall be construed to require or prevent the Contractor from covering services outside of the scope of contracted services (42 CFR 438.6(e)).

3.1.12 The Contractor may limit the provision of contracted services to participating providers except as specifically provided in this Contract; and the following provisions

3.1.12.1 Emergency services;

3.1.12.2 Outside the Service Areas as necessary to provide medically necessary services; and

3.1.12.3 Coordination of Benefits, when an enrollee has other primary comparable medical coverage as necessary to coordinate benefits.

3.1.13 Within the Service Areas:

3.1.13.1 Within the Contractor's service areas, as defined in the Service Areas provisions of the Enrollment Section of this Contract, the Contractor shall cover enrollees for all medically necessary services included in the scope of services covered by this Contract.

3.1.14 Outside the Service Areas:

3.1.14.1 For the enrollees still enrolled with the Contractor who are temporarily outside of the service areas or who have moved to a service area not served by the Contractor, the Contractor shall cover the following services:

3.1.14.1.1 Emergency and post-stabilization services.

3.1.14.1.2 Urgent care services associated with the presentation of medical signs that require immediate attention, but are not life threatening. The Contractor may require prior-authorization for

urgent care services as long as the wait times specified in the, Appointment Standards provisions of the Access Section of this Contract, are not exceeded.

3.1.14.1.3 Services that are neither emergent nor urgent, but are medically necessary and cannot reasonably wait until enrollee's return to the service area. The Contractor is not required to cover non-symptomatic (i.e., preventive care) out of the service area. The Contractor may require prior-authorization for such services as long as the wait times specified in the Appointment Standards provision of the Access Section of this Contract are not exceeded.

3.1.14.1.4 The Contractor is not responsible for coverage of any services when an enrollee is outside the United States of America and its territories and possessions.

3.2 Enrollee Hospitalized at Enrollment

3.2.1 If an enrollee is in an acute care hospital at the time of enrollment and was not enrolled in HO on the day the enrollee was admitted to the hospital, the Health Care Authority shall be responsible for payment of all inpatient facility and professional services provided from the date of admission until the date the enrollee is discharged from an acute care hospital.

3.2.2 If an enrollee is enrolled in HO on the day the enrollee was admitted to an acute care hospital, then the contractor the enrollee is enrolled with on the date of admission shall be responsible for payment of all covered inpatient facility and professional services provided from the date of admission until the date the enrollee is discharged from to an acute care hospital.

3.2.3 For newborns, born while their mother is hospitalized, the party responsible for the payment of covered services for the mother's hospitalization shall be responsible for payment of all covered inpatient facility and professional services provided to the newborn from the date of admission until the date the enrolled newborn is discharged from to an acute care hospital.

3.2.4 If the Health Care Authority is responsible for payment of labor and delivery services provided to a mother, the Health Care Authority shall not pay the Contractor a Delivery Case Rate under the provisions of the Payment Section of this Contract.

3.3 Enrollee Hospitalized at Termination of Enrollment

If an enrollee is in an acute care hospital at the time of termination of enrollment and the enrollee was enrolled with the Contractor on the date of admission, the

Contractor shall be responsible for payment of all covered inpatient facility and professional services from the date of admission until one of the following occurs:

3.3.1 The enrollee is discharged from an acute care hospital.

3.3.2 The enrollee's eligibility to receive Medicaid services ends. The Contractor's obligation for payment ends at the end of the month the enrollees Medicaid eligibility ends.

3.4 Specific Re uirements for Contracted Services

3.4.1 When an enrollee has an alcohol and/or chemical dependency and/or mental health diagnosis, the Contractor is responsible for contracted services whether or not the enrollee is also receiving alcohol and/or chemical dependency and/or mental health treatment.

3.4.2 The Contractor is responsible for services at nursing facilities (licensed under RCW 18.51) when nursing facility services are not covered by the DSHS Aging and Disability Services Administration and the Contractor determines that nursing facility care is more appropriate than an acute hospital care. Inpatient physical rehabilitation services are included.

3.4.3 Emergency Services and Post-stabilization Services:

3.4.3.1 Emergency Services: Emergency services are defined in this Contract.

3.4.3.1.1 Except for those inpatient service specifically excluded for CPE hospitals, the Contractor will provide all inpatient and outpatient emergency services in accord with the requirements of 42 CFR 438.114.

3.4.3.1.2 The Contractor shall cover all emergency services provided by a licensed provider, acting within their scope of practice, without regard to whether the provider is a participating or non-participating provider (42 CFR 438.114 (c)(1)(i)).

3.4.3.1.3 The Contractor shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider or the Contractor of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services (42 CFR 438.114 (c)(1)(ii)).

3.4.3.1.4 <u>The only exclusions to the Contractor's coverage of emergency services are:</u>

3.4.3.1.4.1 Mental health services which are covered under separate contract with DSHS; and

3.4.3.1.4.2 Dental services only if provided by a dentist or an oral surgeon to treat a dental diagnosis, covered under HCAs' fee-for-service program.

3.4.3.1.5 Emergency services shall be provided without requiring prior authorization.

3.4.3.1.6 What constitutes an emergency medical condition may not be limited on the basis of lists of diagnoses or symptoms (42 CFR 438.114 (d)(1)(i)).

3.4.3.1.7 The Contractor shall cover treatment obtained under the following circumstances:

3.4.3.1.7.1 An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition (42 CFR 438.114(c)(1)(ii)(A)).

3.4.3.1.7.2 A participating provider or other Contractor representative instructs the enrollee to seek emergency services (42 CFR 438.114(c)(1)(ii)(B)).

3.4.3.1.8 If there is a disagreement between a hospital and the Contractor concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails and is binding on the Contractor (42 CFR 438.114 (d)(3)).

3.4.4 Post-stabilization Services:

3.4.4.1 The Contractor shall limit post-stabilization services for non-emergent conditions in accord with the Health Care Authority's Billing Instructions for coverage of non-emergent condition.

3.4.4.2 The Contractor will provide all inpatient and outpatient post-stabilization services in accord with the requirements of 42 CFR 438.114 and 42 CFR

422.113(c).

3.4.4.3 The Contractor shall cover all post-stabilization services provided by a licensed provider, acting within their scope of practice, without regard to whether the provider is a participating or non-participating provider.

3.4.4.4 The Contractor shall cover post-stabilization services under the following circumstances (42 CFR 438.114 (e) and 42 CFR 438.113(c)(2)(iii)):

3.4.4.4.1 The services are pre-approved by a participating provider or other Contractor representative.

3.4.4.4.2 The services are not pre-approved by a participating provider or other Contractor representative, but are administered to maintain the enrollee's stabilized condition within 1 hour of a request to the Contractor for pre-approval of further post-stabilization care services.

3.4.4.4.3 The services are not pre-approved by a participating provider or other Contractor representative, but are administered to maintain, improve, or resolve the enrollee's stabilized condition and the the Contractor does not respond to a request for pre-approval within thirty (30) minutes (RCW 48.43.093(d)), the Contractor cannot be contacted or the Contractor representative and the treating physician cannot reach an agreement concerning the enrollee's care and a Contractor physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with care of the enrollee until a Contractor physician is reached or one of the criteria identified in 42 CFR 438.114(e) and 42 CFR 422.133(c)(3) is met.

3.4.4.4.3.1 The Contractor’s responsibility for post-stabilization services it has not pre-approved ends when (42 CFR 438.114(e) and 42 CFR 422.133(c)(3)):

3.4.4.4.3.1.1 A participating provider with privileges at the treating hospital assumes responsibility for the enrollee's care;

3.4.4.4.3.1.2 A participating provider assumes responsibility for the enrollee's care through transfer;

3.4.4.4.3.1.3 A Contractor representative and the treating physician reach an agreement concerning the enrollee's care; or

3.4.4.4.3.1.4 The enrollee is discharged.

3.4.5 Outpatient Mental Health

3.4.5.1 Psychiatric and psychological testing, evaluation and diagnosis:

3.4.5.1.1 Once every twelve (12) months for adults twenty-one (21) and over and children under age twenty-one when not ordered as a result of an EPSDT exam.

3.4.5.1.2 Unlimited for children under age twenty-one (21) when identified in an EPSDT exam.

3.4.5.2 Unlimited medication management:

3.4.5.2.1 Provided by the PCP or by PCP referral.

3.4.5.2.2 Provided in conjunction with mental health treatment covered by the Contractor.

3.4.5.3 For enrollees who do not meet the RSNs' access standards for receiving treatment, twelve hours per calendar year for treatment of adults and twenty hours per calendar year for treatment of children eighteen years of age and younger.

3.4.5.4 Transition to the RSN, as appropriate to the enrollee's condition to assure continuity of care.

3.4.5.5 The Contractor may subcontract with RSNs to provide

the outpatient mental health services that are the responsibility of the Contractor. Such contracts shall not be written or construed in a manner that provides less than the services otherwise described in this Section as the Contractor's responsibility for outpatient mental health services.

3.4.5.6 The Contractor shall review the psychotropic medications of all children under five years of age and establish written policies and procedures for the evaluation of the appropriateness of the psychotropic medications these children are using, including but not limited to the requirement to obtain a second opinion from an expert in child psychiatry prior to prescribing or continuing to prescribe such medication.

3.4.5.7 To assist primary care providers (PCP) in meeting the needs of Enrollees who are children with a mental health diagnosis, the Contractor shall provide PCPs access to consultation with a child psychiatrist. The Contractor may use the Partnership Access Line (PAL) or the equivalent. If the Contractor does not use the PAL, the Contractor will be responsible for the cost of the consulting psychiatrist for the service and must provide the name of the child psychiatrist providing the service and the written agreement for the service to the Health Care Authority. The Contractor is responsible for payment to the PCP for accessing the PAL or an equivalent.

3.4.6 Neurodevelopmental Services, Occupational Therapy, Speech Therapy, and Physical Therapy: Services for the restoration or maintenance of a function affected by an enrollee's illness, disability, condition or injury, or for the amelioration of the effects of a developmental disability when provided by a facility that is not a Department of Health (DOH) recognized neurodevelopmental center. The Contractor may refer children to a DOH recognized neurodevelopmental center for the services as long as appointment wait time standards and access to care standards of this Contract are met.

3.4.7 Pharmaceutical Products:

3.4.7.1 Prescription drug products according to a the Health Care Authority approved formulary, which includes both legend and over-the-counter (OTC) products. The Contractor's formulary shall include all therapeutic classes in the Health Care Authority' fee-for-service drug file and a sufficient variety of drugs in each therapeutic class to meet enrollees' medically necessary health care needs. The Contractor shall provide participating pharmacies

and participating providers with its formulary and information about how to request non-formulary drugs.

3.4.7.2 The Contractor shall have in place a mechanism to deny prescriptions written by excluded providers.

3.4.7.3 The Contractor's policies and procedures for the administration of the pharmacy benefit shall ensure compliance with the following requirements described in this section:

3.4.7.3.1 Formulary exceptions:

3.4.7.3.1.1 The Contractor shall approve or deny all requests for non-formulary drugs by the business day following the day of request.

3.4.7.3.2 Emergency drug supply:

3.4.7.3.2.1 The Contractor shall have a process for providing an emergency drug supply to enrollees when a delay in authorization would interrupt a drug therapy that must be continuous or when the delay would pose a threat to the enrollees' health and safety. The drug supply provided must be sufficient to bridge the time until an authorization determination is made.

3.4.8 Newborn Screenings:

3.4.8.1 The Contractor shall cover all newborn screenings required by the Department of Health.

3.4.9 Early and Periodic Screening, Diagnostic and Treatment (EPSDT):

3.4.9.1 The Contractor shall meet all requirements under the the Health Care Authority EPSDT program policy and billing instructions, incorporated by reference.

3.4.9.2 If a service in determined to be medically necessary through EPSDT, the Contract will provide the service, whether or not it is a contracted service, unless it is specifically excluded or prohibited by Federal rules.

3.4.10 Services to Inmates of Correctional Facilities: The Contractor shall provide inpatient hospital services to enrollees who were inmates of correctional facilities, but are admitted to the hospital for an overnight stay. When an enrollee who was an inmate of a correctional facility is admitted to the hospital, the Contractor will submit all necessary information to HCA regarding the admission. HCA will determine if the enrollee is eligible for coverage of the hospital stay. If HCA determines that the enrollee is eligible for coverage, the Contractor is responsible for the hospital stay and all associated services.

3.5 Enrollee Self-Referral

3.5.1 Enrollees have the right to self-refer for certain services to local health departments and family planning clinics paid through separate arrangements with the State of Washington.

3.5.2 The Contractor is not responsible for the coverage of the services provided through such separate arrangements.

3.5.3 The enrollees also may choose to receive such services from the Contractor.

3.5.4 The Contractor shall assure that enrollees are informed, whenever appropriate, of all options in such a way as not to prejudice or direct the enrollee's choice of where to receive the services. If the Contractor in any manner deprives enrollees of their free choice to receive services through the Contractor, the Contractor shall pay the local health department or family planning facility for services provided to enrollees up to the limits described herein.

3.5.5 Contractor shall offer a provider subcontract to all family planning agencies contracted with the Health Care Authority and make a reasonable and fair effort to subcontract with such agencies for contracted services that are provided by the family planning agencies.

3.5.6 If the Contractor subcontracts with local health departments or family planning clinics as participating providers or refers enrollees to them to receive services, the Contractor shall pay the local health department or family planning facility for services provided to enrollees up to the limits described herein.

3.5.7 The services to which an enrollee may self-refer are:

3.5.7.1 Family planning services and sexually-transmitted disease screening and treatment services provided at family planning agencies, such as Planned Parenthood.

3.5.7.2 Immunizations, sexually-transmitted disease screening and follow-up, immunodeficiency virus (HIV) screening, tuberculosis screening and follow-up, and family planning services through the local health department.

3.6 Exclusions

The following services and supplies are excluded from coverage under this Contract.

3.6.1 Unless otherwise required by this Contract, ancillary services resulting from or ordered in the course of non-contracted services are also non-contracted services.

3.6.2 Complications resulting from an excluded service are also excluded for a period of thirty (30) calendar days following the occurrence of the excluded service not counting the date of service. Thereafter, complications resulting from an excluded service area covered service when they would otherwise be a covered service under the provisions of this Contract.

3.6.3 The following covered services are provided by the State as described in the billing instructions and are not contracted services. The Contractor is responsible for coordinating these services for the enrollee. Some services are only provided to children under the age of 21.

3.6.3.1 Inpatient services at Certified Public Expenditure (CPE) hospitals for Categorically Needy – Blind and Disabled enrollees identified by the Health Care Authority.

3.6.3.2 School Medical Services for Special Students

3.6.3.3 Eyeglass frames, lenses, and fabrication services covered under the Health Care Authority's selective contract for these services, and associated fitting and dispensing services

3.6.3.4 Voluntary Termination of Pregnancy.

3.6.3.5 Transportation Services other than ambulance including but not limited to taxi, cabulance, voluntary transportation, public transportation and common carriers.

3.6.3.6 Services provided by dentists and oral surgeons for dental diagnoses, and anesthesia for dental care.

3.6.3.7 Hearing aid devices, including fitting, follow-up care and repair.

3.6.3.8 Maternity Support Services/Infant Case Management.

3.6.3.9 Sterilizations for enrollees under age twenty-one (21), or those that do not meet other federal requirements (42 CFR 441 Subpart F).

3.6.3.10 Health care services provided by a neurodevelopmental center recognized by the Department of Health.

3.6.3.11 Services provided by a health department when a client self-refers for care if the health department is not contracted with the Contractor.

3.6.3.12 Inpatient psychiatric services

3.6.3.13 Pharmaceutical products prescribed by any provider related to services provided under a separate contract with the Health Care Authority.

3.6.3.14 Laboratory services required for medication management of drugs prescribed by RSN community mental health providers whose services are purchased by the the Department of Social and Health Services (DSHS).

3.6.3.15 Surgical procedures for weight loss or reduction, when approved by the Health Care Authority in accord with WAC 182-531-0200. The Contractor has no obligation to cover surgical procedures for weight loss or reduction. The Contractor should cover the initial health care assessment for entry to the weight loss surgical program.

3.6.3.16 Prenatal Diagnosis Genetic Counseling provided to enrollees to allow enrollees and their PCPs to make informed decisions regarding current genetic practices and testing.

3.6.3.17 Substance use treatment services covered through the DSHS, Division of Behavioral Health and Recovery Services (DBHR)).

3.6.3.18 Community-based services (e.g., COPES and Personal Care Services) covered through the Aging and Disability Services Administration.

3.6.3.19 Nursing facilities covered through the Aging and

Disability Services Administration.

3.6.3.20 Mental health services separately purchased for all Medicaid clients by the DSHS, DBHR,.

3.6.3.21 Health care services covered through the DSHS, Division of Developmental Disabilities for institutionalized clients.

3.6.3.22 Infant formula for oral feeding provided by the Women, Infants and Children (WIC) program in the Department of Health. Medically necessary nutritional supplements for infants are covered under the pharmacy benefit.

3.6.3.23 Services Excluded by the Health Care Authority in accord with WAC 182-501-0070.

3.6.3.24 Any service provided to an enrollee, while an inmate of a correctional facility, except as provided herein.

3.7 Coordination of Benefits and Subrogation of Rights of Third Party Liability

3.7.1 Coordination of Benefits:

3.7.1.1 Until the Health Care Authority ends the enrollment of an enrollee who has comparable coverage as described in the Enrollment Section of this Contract, the services and benefits available under this Contract shall be secondary to any other medical coverage.

3.7.1.2 Nothing in this Section negates any of the Contractor's responsibilities under this Contract including, but not limited to, the requirement described in the Prohibition on Enrollee Charges for Contracted Services provisions of the Enrollee Rights and Protections Section of this Contract. The Contractor shall:

3.7.1.2.1 Not refuse or reduce services provided under this Contract solely due to the existence of similar benefits provided under any other health care contracts (RCW 48.21.200), except in accord with applicable coordination of benefits rules in WAC 284-51.

3.7.1.2.2 Attempt to recover any third-party resources available to enrollees (42 CFR 433 Subpart D) and shall make all records pertaining to coordination of benefits collections for enrollees available for audit and review.

3.7.1.2.3 Pay claims for prenatal care and preventive pediatric care and then seek reimbursement from third parties (42 CFR 433.139(b)(3)).

3.7.1.2.4 Pay claims for contracted services when probable third party liability has not been established or the third party benefits are not available to pay a claim at the time it is filed (42 CFR 433.139(c)).

3.7.1.2.5 Communicate the requirements of this Section to subcontractors that provide services under the terms of this Contract, and assure compliance with them.

3.7.2 Subrogation Rights of Third-Party Liability:

3.7.2.1 Injured person means an enrollee covered by this Contract who sustains bodily injury.

3.7.2.2 Contractor's medical expense means the expense incurred by the Contractor for the care or treatment of the injury sustained computed in accord with the Contractor's fee-for-service schedule.

3.7.2.3 If an enrollee requires medical services from the Contractor as a result of an alleged act or omission by a third-party giving rise to a claim of legal liability against the third-party, the Contractor shall have the right to obtain recovery of its cost of providing benefits to the injured person from the third-party.

3.7.2.4 The Health Care Authority specifically assigns to the Contractor the Health Care Authority's rights to such third party payments for medical care provided to an enrollee on behalf of the Health Care Authority, which the enrollee assigned to the Health Care Authority as provided in WAC 388-505-0540.

3.7.2.5 The Health Care Authority also assigns to the Contractor its statutory lien under RCW 43.20B.060. The Contractor shall be subrogated to the Health Care Authority's rights and remedies under RCW 74.09.180 and RCW 43.20B.040 through RCW 43.20B.070 with respect to medical benefits provided to enrollees on behalf of the Health Care Authority under RCW 74.09.

3.7.2.6 The Contractor may obtain a signed agreement from the enrollee in which the enrollee agrees to fully cooperate in effecting collection from persons causing the injury. The agreement may provide that if an injured party settles a

claim without protecting the Contractor's interest, the injured party shall be liable to the Contractor for the full cost of medical services provided by the Contractor.

3.7.2.7 The Contractor shall notify the Health Care Authority of the name, address, and other identifying information of any enrollee and the enrollee's attorney who settles a claim without protecting the Contractor's interest in contravention of RCW 43.20B.050.

3.8 Patient Review and Coordination (PRC)

3.8.1 The Contractor shall have a PRC program that meets the requirements of WAC 182-501-0135. PRC is authorized by 42 USC 1396n (a)(2) and 42 CFR 431.54.

3.8.2 If either the Contractor or the Health Care Authority places an enrollee into the PRC program, both parties will honor that placement.

3.8.3 The Contractor's placement of an enrollee into the PRC program shall be considered an action, which shall be subject to appeal under the provisions of the Grievance System section of this Contract. If the enrollee appeals the PRC placement the Contractor will notify the Health Care Authority of the appeal and the outcome.

3.8.4 When an enrollee is placed in the Contractor's PRC program, the Contractor shall send the enrollee a written notice of the enrollee's PRC placement, or any change of status, in accord with the requirements of WAC 182-501-0135.

3.8.5 The Contractor shall send the Health Care Authority a written notice of the enrollee's PRC placement, or any change of status, in accord with the required format provided in the Patient Review and Coordination Program Guide published by the Health Care Authority.

3.8.6 In accord with WAC 182-501-0135, the Health Care Authority will limit the ability of an enrollee placed in the PRC program to change their enrolled contractor for twelve months after the enrollee is in the PRC program by the Health Care Authority or the Contractor unless the PRC enrollee moves to a residence outside the Contractor's service areas.

3.8.7 If the Health Care Authority limits the ability of an enrollee to change their enrolled contractor family members may still change enrollment as provided in this Contract.

Rate Confirmation-- Healthy Options July 2012 - December 2013 Capitation Rates

Contractor: UnitedHealthcare Community Plan

		Female Capitation Rates						
	Age Factors	3.052	0.751	0.494	1.001	2.218	2.987	2.909
County	Quality Factor *	Age <1	Age 1 - 2	Age 3 - 14	Age 15 - 18	Age 19 - 34	Age 35 - 64	Age 65+
Adams		$ 409.25	$ 100.70	$ 66.24	$ 134.23	$ 297.42	$ 400.53	$ 390.08
Asotin		$ 409.25	$ 100.70	$ 66.24	$ 134.23	$ 297.42	$ 400.53	$ 390.08
Benton		$ 446.28	$ 109.82	$ 72.24	$ 146.37	$ 324.33	$ 436.78	$ 425.37
Chelan		$ 464.32	$ 114.26	$ 75.16	$ 152.29	$ 337.44	$ 454.44	$ 442.57
Clallam		$ 434.41	$ 106.90	$ 70.31	$ 142.48	$ 315.70	$ 425.16	$ 414.06
Clark		-	-	-	-	-	-	-
Columbia		$ 434.41	$ 106.90	$ 70.31	$ 142.48	$ 315.70	$ 425.16	$ 414.06
Cowlitz		$ 464.32	$ 114.26	$ 75.16	$ 152.29	$ 337.44	$ 454.44	$ 442.57
Douglas		$ 464.32	$ 114.26	$ 75.16	$ 152.29	$ 337.44	$ 454.44	$ 442.57
Ferry		$ 510.38	$ 125.59	$ 82.61	$ 167.39	$ 370.91	$ 499.51	$ 486.46
Franklin		$ 434.41	$ 106.90	$ 70.31	$ 142.48	$ 315.70	$ 425.16	$ 414.06
Garfield		$ 464.32	$ 114.26	$ 75.16	$ 152.29	$ 337.44	$ 454.44	$ 442.57
Grant		$ 446.28	$ 109.82	$ 72.24	$ 146.37	$ 324.33	$ 436.78	$ 425.37
Grays Harbor		$ 464.32	$ 114.26	$ 75.16	$ 152.29	$ 337.44	$ 454.44	$ 442.57
Island		$ 542.66	$ 133.53	$ 87.84	$ 177.98	$ 394.37	$ 531.10	$ 517.23
Jefferson		$ 510.38	$ 125.59	$ 82.61	$ 167.39	$ 370.91	$ 499.51	$ 486.46
King		$ 409.25	$ 100.70	$ 66.24	$ 134.23	$ 297.42	$ 400.53	$ 390.08
Kitsap		$ 464.32	$ 114.26	$ 75.16	$ 152.29	$ 337.44	$ 454.44	$ 442.57
Kittitas		$ 464.32	$ 114.26	$ 75.16	$ 152.29	$ 337.44	$ 454.44	$ 442.57
Klickitat		$ 510.38	$ 125.59	$ 82.61	$ 167.39	$ 370.91	$ 499.51	$ 486.46
Lewis		$ 510.38	$ 125.59	$ 82.61	$ 167.39	$ 370.91	$ 499.51	$ 486.46
Lincoln		$ 510.38	$ 125.59	$ 82.61	$ 167.39	$ 370.91	$ 499.51	$ 486.46
Mason		$ 510.38	$ 125.59	$ 82.61	$ 167.39	$ 370.91	$ 499.51	$ 486.46
Okanogan		$ 487.59	$ 119.98	$ 78.92	$ 159.92	$ 354.35	$ 477.20	$ 464.74
Pacific		$ 446.28	$ 109.82	$ 72.24	$ 146.37	$ 324.33	$ 436.78	$ 425.37
Pend Oreille		$ 510.38	$ 125.59	$ 82.61	$ 167.39	$ 370.91	$ 499.51	$ 486.46
Pierce		$ 487.59	$ 119.98	$ 78.92	$ 159.92	$ 354.35	$ 477.20	$ 464.74
San Juan		$ 434.41	$ 106.90	$ 70.31	$ 142.48	$ 315.70	$ 425.16	$ 414.06
Skagit		$ 446.28	$ 109.82	$ 72.24	$ 146.37	$ 324.33	$ 436.78	$ 425.37
Skamania		$ 542.66	$ 133.53	$ 87.84	$ 177.98	$ 394.37	$ 531.10	$ 517.23
Snohomish		$ 464.32	$ 114.26	$ 75.16	$ 152.29	$ 337.44	$ 454.44	$ 442.57
Spokane		$ 464.32	$ 114.26	$ 75.16	$ 152.29	$ 337.44	$ 454.44	$ 442.57
Stevens		$ 510.38	$ 125.59	$ 82.61	$ 167.39	$ 370.91	$ 499.51	$ 486.46
Thurston		$ 464.32	$ 114.26	$ 75.16	$ 152.29	$ 337.44	$ 454.44	$ 442.57
Wahkiakum		$ 510.38	$ 125.59	$ 82.61	$ 167.39	$ 370.91	$ 499.51	$ 486.46
Walla Walla		$ 434.41	$ 106.90	$ 70.31	$ 142.48	$ 315.70	$ 425.16	$ 414.06
Whatcom		$ 409.25	$ 100.70	$ 66.24	$ 134.23	$ 297.42	$ 400.53	$ 390.08
Whitman		$ 464.32	$ 114.26	$ 75.16	$ 152.29	$ 337.44	$ 454.44	$ 442.57
Yakima		$ 434.41	$ 106.90	$ 70.31	$ 142.48	$ 315.70	$ 425.16	$ 414.06

	Male Capitation Rates						
3.052	0.751	0.494	0.762	1.212	2.429	2.909
Age <1	Age 1 - 2	Age 3 - 14	Age 15 - 18	Age 19 - 34	Age 35 - 64	Age 65+
$409.25	$ 100.70	$ 66.24	$ 102.18	$ 162.52	$ 325.71	$ 390.08
$409.25	$ 100.70	$ 66.24	$ 102.18	$ 162.52	$ 325.71	$ 390.08
$446.28	$ 109.82	$ 72.24	$ 111.42	$ 177.23	$ 355.18	$ 425.37
$464.32	$ 114.26	$ 75.16	$ 115.93	$ 184.39	$ 369.54	$ 442.57
$434.41	$ 106.90	$ 70.31	$ 108.46	$ 172.51	$ 345.74	$ 414.06
-	-	-	-	-	-	-
$434.41	$ 106.90	$ 70.31	$ 108.46	$ 172.51	$ 345.74	$ 414.06
$464.32	$ 114.26	$ 75.16	$ 115.93	$ 184.39	$ 369.54	$ 442.57
$464.32	$ 114.26	$ 75.16	$ 115.93	$ 184.39	$ 369.54	$ 442.57
$510.38	$ 125.59	$ 82.61	$ 127.43	$ 202.68	$ 406.19	$ 486.46
$434.41	$ 106.90	$ 70.31	$ 108.46	$ 172.51	$ 345.74	$ 414.06
$464.32	$ 114.26	$ 75.16	$ 115.93	$ 184.39	$ 369.54	$ 442.57
$446.28	$ 109.82	$ 72.24	$ 111.42	$ 177.23	$ 355.18	$ 425.37
$464.32	$ 114.26	$ 75.16	$ 115.93	$ 184.39	$ 369.54	$ 442.57
$542.66	$ 133.53	$ 87.84	$ 135.49	$ 215.50	$ 431.89	$ 517.23
$510.38	$ 125.59	$ 82.61	$ 127.43	$ 202.68	$ 406.19	$ 486.46
$409.25	$ 100.70	$ 66.24	$ 102.18	$ 162.52	$ 325.71	$ 390.08
$464.32	$ 114.26	$ 75.16	$ 115.93	$ 184.39	$ 369.54	$ 442.57
$464.32	$ 114.26	$ 75.16	$ 115.93	$ 184.39	$ 369.54	$ 442.57
$510.38	$ 125.59	$ 82.61	$ 127.43	$ 202.68	$ 406.19	$ 486.46
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$510.38	$ 125.59	$ 82.61	$ 127.43	$ 202.68	$ 406.19	$ 486.46
$510.38	$ 125.59	$ 82.61	$ 127.43	$ 202.68	$ 406.19	$ 486.46
$487.59	$ 119.98	$ 78.92	$ 121.74	$ 193.63	$ 388.06	$ 464.74
$446.28	$ 109.82	$ 72.24	$ 111.42	$ 177.23	$ 355.18	$ 425.37
$510.38	$ 125.59	$ 82.61	$ 127.43	$ 202.68	$ 406.19	$ 486.46
$487.59	$ 119.98	$ 78.92	$ 121.74	$ 193.63	$ 388.06	$ 464.74
$434.41	$ 106.90	$ 70.31	$ 108.46	$ 172.51	$ 345.74	$ 414.06
$446.28	$ 109.82	$ 72.24	$ 111.42	$ 177.23	$ 355.18	$ 425.37
$542.66	$ 133.53	$ 87.84	$ 135.49	$ 215.50	$ 431.89	$ 517.23
$464.32	$ 114.26	$ 75.16	$ 115.93	$ 184.39	$ 369.54	$ 442.57
$464.32	$ 114.26	$ 75.16	$ 115.93	$ 184.39	$ 369.54	$ 442.57
$510.38	$ 125.59	$ 82.61	$ 127.43	$ 202.68	$ 406.19	$ 486.46
$464.32	$ 114.26	$ 75.16	$ 115.93	$ 184.39	$ 369.54	$ 442.57
$510.38	$ 125.59	$ 82.61	$ 127.43	$ 202.68	$ 406.19	$ 486.46
$434.41	$ 106.90	$ 70.31	$ 108.46	$ 172.51	$ 345.74	$ 414.06
$409.25	$ 100.70	$ 66.24	$ 102.18	$ 162.52	$ 325.71	$ 390.08
$464.32	$ 114.26	$ 75.16	$ 115.93	$ 184.39	$ 369.54	$ 442.57
$434.41	$ 106.90	$ 70.31	$ 108.46	$ 172.51	$ 345.74	$ 414.06

* The Quality Factor will be applied as a rate amendment.

Rate Confirmation-- Healthy Options SSI July 2012 - December 2013 Capitation Rates

Contractor: UnitedHealthcare Community Plan

		Female Capitation Rates						Male Capitation Rates					
	Age Factors	3.885	2.126	0.759	0.715	0.803	1.161	3.885	2.126	0.759	0.889	0.745	1.037
County	Quality Factor *	Age <1	Age 1 - 2	Age 3 - 14	Age 15 - 18	Age 19 - 34	Age 35+	Age <1	Age 1 - 2	Age 3 - 14	Age 15 - 18	Age 19 - 34	Age 35+
Adams		$ 3,330.78	$ 1,822.71	$ 650.72	$ 613.00	$ 688.45	$ 995.37	$3,330.78	$1,822.71	$ 650.72	$ 762.18	$ 638.72	$ 889.06
Asotin		$ 2,633.81	$ 1,441.31	$ 514.56	$ 484.73	$ 544.39	$ 787.09	$2,633.81	$1,441.31	$ 514.56	$ 602.69	$ 505.07	$ 703.03
Benton		$ 2,633.81	$ 1,441.31	$ 514.56	$ 484.73	$ 544.39	$ 787.09	$2,633.81	$1,441.31	$ 514.56	$ 602.69	$ 505.07	$ 703.03
Chelan		$ 2,534.76	$ 1,387.11	$ 495.21	$ 466.50	$ 523.92	$ 757.49	$2,534.76	$1,387.11	$ 495.21	$ 580.03	$ 486.07	$ 676.59
Clallam		$ 2,534.76	$ 1,387.11	$ 495.21	$ 466.50	$ 523.92	$ 757.49	$2,534.76	$1,387.11	$ 495.21	$ 580.03	$ 486.07	$ 676.59
Clark		-	-	-	-	-	-	-	-	-	-	-	-
Columbia		$ 3,033.65	$ 1,660.11	$ 592.67	$ 558.32	$ 627.03	$ 906.58	$3,033.65	$1,660.11	$ 592.67	$ 694.19	$ 581.74	$ 809.75
Cowlitz		$ 2,861.24	$ 1,565.76	$ 558.99	$ 526.59	$ 591.40	$ 855.06	$2,861.24	$1,565.76	$ 558.99	$ 654.73	$ 548.68	$ 763.73
Douglas		$ 2,534.76	$ 1,387.11	$ 495.21	$ 466.50	$ 523.92	$ 757.49	$2,534.76	$1,387.11	$ 495.21	$ 580.03	$ 486.07	$ 676.59
Ferry		$ 2,685.16	$ 1,469.41	$ 524.59	$ 494.18	$ 555.00	$ 802.44	$2,685.16	$1,469.41	$ 524.59	$ 614.44	$ 514.92	$ 716.73
Franklin		$ 3,033.65	$ 1,660.11	$ 592.67	$ 558.32	$ 627.03	$ 906.58	$3,033.65	$1,660.11	$ 592.67	$ 694.19	$ 581.74	$ 809.75
Garfield		$ 3,330.78	$ 1,822.71	$ 650.72	$ 613.00	$ 688.45	$ 995.37	$3,330.78	$1,822.71	$ 650.72	$ 762.18	$ 638.72	$ 889.06
Grant		$ 2,685.16	$ 1,469.41	$ 524.59	$ 494.18	$ 555.00	$ 802.44	$2,685.16	$1,469.41	$ 524.59	$ 614.44	$ 514.92	$ 716.73
Grays Harbor		$ 2,685.16	$ 1,469.41	$ 524.59	$ 494.18	$ 555.00	$ 802.44	$2,685.16	$1,469.41	$ 524.59	$ 614.44	$ 514.92	$ 716.73
Island		$ 2,633.81	$ 1,441.31	$ 514.56	$ 484.73	$ 544.39	$ 787.09	$2,633.81	$1,441.31	$ 514.56	$ 602.69	$ 505.07	$ 703.03
Jefferson		$ 3,033.65	$ 1,660.11	$ 592.67	$ 558.32	$ 627.03	$ 906.58	$3,033.65	$1,660.11	$ 592.67	$ 694.19	$ 581.74	$ 809.75
King		$ 2,685.16	$ 1,469.41	$ 524.59	$ 494.18	$ 555.00	$ 802.44	$2,685.16	$1,469.41	$ 524.59	$ 614.44	$ 514.92	$ 716.73
Kitsap		$ 2,534.76	$ 1,387.11	$ 495.21	$ 466.50	$ 523.92	$ 757.49	$2,534.76	$1,387.11	$ 495.21	$ 580.03	$ 486.07	$ 676.59
Kittitas		$ 3,000.63	$ 1,642.05	$ 586.22	$ 552.24	$ 620.21	$ 896.71	$3,000.63	$1,642.05	$ 586.22	$ 686.63	$ 575.41	$ 800.94
Klickitat		$ 3,000.63	$ 1,642.05	$ 586.22	$ 552.24	$ 620.21	$ 896.71	$3,000.63	$1,642.05	$ 586.22	$ 686.63	$ 575.41	$ 800.94
Lewis		$ 2,685.16	$ 1,469.41	$ 524.59	$ 494.18	$ 555.00	$ 802.44	$2,685.16	$1,469.41	$ 524.59	$ 614.44	$ 514.92	$ 716.73
Lincoln		$ 3,330.78	$ 1,822.71	$ 650.72	$ 613.00	$ 688.45	$ 995.37	$3,330.78	$1,822.71	$ 650.72	$ 762.18	$ 638.72	$ 889.06
Mason		$ 2,685.16	$ 1,469.41	$ 524.59	$ 494.18	$ 555.00	$ 802.44	$2,685.16	$1,469.41	$ 524.59	$ 614.44	$ 514.92	$ 716.73
Okanogan		$ 2,685.16	$ 1,469.41	$ 524.59	$ 494.18	$ 555.00	$ 802.44	$2,685.16	$1,469.41	$ 524.59	$ 614.44	$ 514.92	$ 716.73
Pacific		$ 3,033.65	$ 1,660.11	$ 592.67	$ 558.32	$ 627.03	$ 906.58	$3,033.65	$1,660.11	$ 592.67	$ 694.19	$ 581.74	$ 809.75
Pend Oreille		$ 2,685.16	$ 1,469.41	$ 524.59	$ 494.18	$ 555.00	$ 802.44	$2,685.16	$1,469.41	$ 524.59	$ 614.44	$ 514.92	$ 716.73
Pierce		$ 3,330.78	$ 1,822.71	$ 650.72	$ 613.00	$ 688.45	$ 995.37	$3,330.78	$1,822.71	$ 650.72	$ 762.18	$ 638.72	$ 889.06
San Juan		$ 2,534.76	$ 1,387.11	$ 495.21	$ 466.50	$ 523.92	$ 757.49	$2,534.76	$1,387.11	$ 495.21	$ 580.03	$ 486.07	$ 676.59
Skagit		$ 2,633.81	$ 1,441.31	$ 514.56	$ 484.73	$ 544.39	$ 787.09	$2,633.81	$1,441.31	$ 514.56	$ 602.69	$ 505.07	$ 703.03
Skamania		$ 3,330.78	$ 1,822.71	$ 650.72	$ 613.00	$ 688.45	$ 995.37	$3,330.78	$1,822.71	$ 650.72	$ 762.18	$ 638.72	$ 889.06
Snohomish		$ 3,000.63	$ 1,642.05	$ 586.22	$ 552.24	$ 620.21	$ 896.71	$3,000.63	$1,642.05	$ 586.22	$ 686.63	$ 575.41	$ 800.94
Spokane		$ 3,033.65	$ 1,660.11	$ 592.67	$ 558.32	$ 627.03	$ 906.58	$3,033.65	$1,660.11	$ 592.67	$ 694.19	$ 581.74	$ 809.75
Stevens		$ 3,033.65	$ 1,660.11	$ 592.67	$ 558.32	$ 627.03	$ 906.58	$3,033.65	$1,660.11	$ 592.67	$ 694.19	$ 581.74	$ 809.75
Thurston		$ 2,534.76	$ 1,387.11	$ 495.21	$ 466.50	$ 523.92	$ 757.49	$2,534.76	$1,387.11	$ 495.21	$ 580.03	$ 486.07	$ 676.59
Wahkiakum		$ 3,000.63	$ 1,642.05	$ 586.22	$ 552.24	$ 620.21	$ 896.71	$3,000.63	$1,642.05	$ 586.22	$ 686.63	$ 575.41	$ 800.94
Walla Walla		$ 2,861.24	$ 1,565.76	$ 558.99	$ 526.59	$ 591.40	$ 855.06	$2,861.24	$1,565.76	$ 558.99	$ 654.73	$ 548.68	$ 763.73
Whatcom		$ 2,861.24	$ 1,565.76	$ 558.99	$ 526.59	$ 591.40	$ 855.06	$2,861.24	$1,565.76	$ 558.99	$ 654.73	$ 548.68	$ 763.73
Whitman		$ 3,330.78	$ 1,822.71	$ 650.72	$ 613.00	$ 688.45	$ 995.37	$3,330.78	$1,822.71	$ 650.72	$ 762.18	$ 638.72	$ 889.06
Yakima		$ 2,861.24	$ 1,565.76	$ 558.99	$ 526.59	$ 591.40	$ 855.06	$2,861.24	$1,565.76	$ 558.99	$ 654.73	$ 548.68	$ 763.73

* The Quality Factor will be applied as a rate amendment.

Exhibit B
Basic Health Provisions

TABLE OF CONTENTS

1 ELIGIBILITY AND ENROLLMENT

1.1 Eligibility

Eligibility of Basic Health (BH) Subscribers and their Dependents and the terms of their coverage shall be as set forth in the COC (Exhibit B-2), subject to amendment in accordance with current and future provisions of chapter 70.47 RCW and Title 182 WAC.

1.2 Enrollment

Each applicant for enrollment must file an application form with HCA and must fulfill all conditions of enrollment described in the COC (Exhibit B-2). Coverage begins for Enrollees as described in the COC (Exhibit B-2).

At the direction of HCA, Contractor shall enroll any person for whom HCA pays monthly fees on a retroactive basis for Covered Services, even though the person may not have complied with the prescribed time limits for obtaining coverage. When a person has been retroactively enrolled, services covered during that retroactive period may be limited to those provided by Participating Providers, or emergency care services. In addition, with regard to services that require preauthorization, retroactive coverage may be limited to services that would have been preauthorized had the Enrollee been actively enrolled at the time services were provided.

1.3 Limited Enrollment

Upon at least 90 calendar daysô prior written notice, and with prior Contract in writing by HCA, Contractor may limit enrollment for acceptance of new applications for enrollment. Said limitations shall be based on a determination by Contractor that its capacity, in relation to its total enrollment, is not adequate to provide services to additional persons. The consent of HCA will not be unreasonably withheld. HCA may also limit enrollment upon at least 90 calendar daysô written notice to Contractor.

1.4 Identification Cards and Contractor Information

HCA shall:

1.4.1 Publish and make available the COC to all persons enrolled in BH.

1.4.2 Issue a notice to all new Enrollees and Enrollees requesting a change of BH Contractors, providing the following information: (1) the name(s) or other identification of the Enrollee(s) eligible for coverage; (2) the effective date of coverage for each Enrollee; and (3) the BH Contractor selected by the Enrollee(s). This notice will serve as temporary membership identification pending issuance of identification cards by Contractor. An Enrolleeôs out-of-pocket maximum liability begins on the effective date of coverage with Contractor.

Contractor shall:

1.4.3 Respond promptly and courteously to inquiries from Enrollees and candidates for enrollment in BH coverage. Contractor shall provide sufficient, accurate oral and written information to assist Enrollee to make informed decisions about enrollment. Contractor shall provide Enrollees with a summary of benefits, including an Enrolleeôs rights and obligations related to the administration of deductibles, coinsurance, and out-of-pocket maximums. Contractor shall ensure Enrollees have written information about how to obtain care in Contractor's health care system and network and the role of the PCP in providing and authorizing care. Upon request from Enrollee, Contractor shall provide adequate and timely information to Enrollees so that they are informed as to how they can access care and choose an appropriate PCP for coverage prior to their effective date of enrollment with the Contractor.

1.4.4 Submit any materials intended primarily for use by BH Enrollees or candidates for enrollment in BH coverage for approval by HCA prior to distribution. In addition, Contractor must submit to BH a courtesy copy of all other materials sent to BH Enrollees or candidates for enrollment in BH coverage.

1.4.5 Distribute the Contractor's COC to Enrollees enrolled for coverage effective on or after February 1 within 15 business days of receipt of confirmation of enrollment from HCA. Contractor may distribute the COC electronically, following written notice to Enrollees. The written notice must offer Enrollees the option of a hard copy version of the COC free of charge and must also include a self-addressed postcard or envelope along with instructions for obtaining a hard copy of the COC from the Contractor, either by phone request or by mail. If the Enrollee chooses to receive the COC by mail, Contractor must send the Enrollee a hard copy of the COC within 15 business days of receipt of the written notice.

1.4.6 Distribute to Enrollees, upon request, a copy of Contractor's drug formulary or list used for Enrollees covered under the terms of this Contract. Contractor shall ensure Enrollees know how to request a copy of the formulary and that they have timely access to the formulary upon request.

1.4.7 Distribute to Enrollees in writing, at the time of enrollment, or at any time upon request, information about the Contractor's complaint and appeal procedures.

1.4.8 Assist HCA in the distribution of any disclosure forms, benefits descriptions or other material that may be required by HCA, or by any provision of Washington or federal law or by regulation.

1.4.9 Send identification cards to Enrollees. This information must be sent to the Enrollees within 15 business days of receipt of enrollment verification from HCA.

1.4.10 Ensure that Participating Providers accept the HCA-issued notice detailed at Identification Cards and Contractor Information section of this Exhibit as verification of enrollment until an official identification card is issued to the Enrollee by Contractor.

1.4.11 Provide all Participating Providers with timely information so that adequate care for Enrollees can be reasonably assured. Timely information

includes, but is not limited to, enrollment information and, where appropriate, preauthorizations for Covered Services or referrals to Participating and non-Participating Providers. Enrollment data must be available to Participating Providers within 5 business days after receipt from HCA.

1.4.12 Issue Explanation of Benefits (EOB) reflecting patientôs responsibility for claims and accumulated amount toward deductibles and out-of-pocket maximums. Contractor's appropriate staff must have electronic access to an Enrolleeôs benefit history in order to provide timely response to Enrollee queries related to benefit usage.

1.5 Medical Assistance Recipients

Pursuant to RCW 70.47.110, HCA will determine if a BH Plus or Maternity Benefits Program applicant is eligible for Medical Assistance under chapter 74.09 RCW. Any Enrollee on whose behalf HCA makes such payments to Contractor, will be entitled to the BH Plus or the Maternity Benefits Program services set forth in this contract . Contractor agrees to cooperate with HCA in effecting the smooth transfer of Enrollees from BH to BH Plus or the Maternity Benefits Program. Contractor is required to cooperate with HCA to ensure compliance with the BH Plus and Maternity Benefits Program contract terms.

2 MONTHLY FEES

2.1 Remittance

Subject to the provisions of this Contract, HCA shall remit a monthly fee to Contractor on behalf of each Enrollee in full consideration of the work to be performed by Contractor under this Contract. The ñMonthly Feeòspecified in Exhibit B-1, shall be based on HCAôs then current enrollment information. Payment shall be remitted to Contractor on or before the 15th day of the month during which Covered Services are to be provided to eligible Enrollees. Monthly fees for BH Plus and the Maternity Benefits Program are set forth in Exhibit H of this Contract.

2.2 Retroactive Payment or Refund

Retroactive payment or refund of monthly fees to reflect additions or deletions of Enrollees added or omitted based on HCAôs enrollment records will be made by HCA.

2.3 Responsibility for Enrollment Data

2.3.1 HCA will furnish current enrollment information to Contractor upon which Contractor may rely without further verification. HCA may provide enrollment verification by telephone, which will be followed by written or electronic confirmation.

2.4 Renegotiation of Rates

The Monthly Fees set forth in Exhibit B-1 shall be subject to negotiation during the Contract period if HCA determines that changes in federal or state law or regulations materially affect the risk to Contractor or its costs of doing business.

3 SERVICES, BENEFITS, EXCLUSIONS, AND LIMITATIONS

3.1 Plan Description

The services, benefits, exclusions, and limitations applicable to Enrollees are set forth in the COC (Exhibit B-2).

3.2 Scope of Services

3.2.1 The Contractor shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of the enrolleeôs diagnosis, type of illness or condition (42 CFR 438.210(a)(3)(ii).

3.2.2 Except as specifically provided in the provisions of the, Authorization of Services Section, the requirements of this Section shall not be construed to prevent the Contractor from establishing utilization control measures as it deems necessary to assure that services are appropriately utilized, provided that utilization control measures do not deny medically necessary contracted services to enrollees. The Contractorôs utilization control measures are not required to be the same as those in the Medicaid fee-for-service program (42 CFR 438.210(a)(3)(iii).

3.3 Self-Referral for Women's Health Care

3.3.1 Pursuant to WAC 284-43-250, access to womenôs health care Providers may not be restricted based solely on a womanôs choice of PCP. If Contractor restricts access for other services to a subnetwork of fewer than the entire panel of Participating Providers available to all Enrollees, access to womenôs health care services may not be restricted to the same subnetwork, but Enrollees may be required to use a Participating Provider.

3.3.2 If an Enrollee is required to use facilities (such as hospitals) affiliated with her PCP or the PCP's subnetwork for services generally, this limitation may not be imposed for women's health care services. Enrollees may be required to use a Participating Provider facility within Contractor's network.

3.4 Preventive Care

3.4.1 Primary and secondary preventive care services shall be provided in accordance with the edition of the ñGuide to Clinical Preventive Servicesò of the U.S. Preventive Services Task Force as of the effective date of this Contract and as follows:

3.4.1.1 Those services rated ñAò shall be covered and Contractor shall take active steps to assure their provision.

3.4.1.2 Those services rated ñBò shall be covered.

3.4.1.3 Those services rated ñDò shall not be covered.

3.4.1.4 Those services rated ñIò shall not be covered, and Contractor shall take steps to determine that if those services are provided, there is informed consent.

3.4.1.5 Those services rated ñCò and those services not rated shall be provided at the discretion of Contractor to determine the appropriate level of care for the Enrollee consistent with the terms of the COC (Exhibit B-2) and this Contract.

3.4.2 Contractor may substitute generally recognized accepted guidelines, as long as such substitution is approved in advance, in writing, by HCA.

3.4.3 Contractor shall provide the Enrollee with a description of preventive care benefits to be used by Contractor in the materials required by Section 1.5 of this Exhibit.

3.5 Emergency Services and Post-stabilization Services

3.5.1 Emergency Services: Emergency services are defined herein.

3.5.1.1 The Contractor will provide all inpatient and outpatient emergency services in accord with the requirements of 42 CFR 438.114.

3.5.1.2 The Contractor shall cover all emergency services provided by a licensed provider, acting within their scope of practice, without regard to whether the provider is a participating or non-participating provider (42 CFR 438.114 (c)(1)(i)).

3.5.1.3 The Contractor shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, or the Contractor of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services (42 CFR 438.114 (c)(1)(ii)).

3.5.1.4 Emergency services shall be provided without requiring prior authorization.

3.5.1.5 What constitutes an emergency medical condition may not be limited on the basis of lists of diagnoses or symptoms (42 CFR 438.114 (d)(1)(i)).

3.5.1.6 An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient (42 CFR 438.114(d)(2).

3.5.1.7 The Contractor shall cover treatment obtained under the following circumstances:

3.5.1.7.1 An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition (42 CFR 438.114(c)(1)(ii)(A)).

3.5.1.7.2 A participating provider or other Contractor representative instructs the enrollee to seek emergency services (42 CFR 438.114(c)(1)(ii)(B)).

3.5.1.8 If there is a disagreement between a hospital and the Contractor concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending

physician(s) actually caring for the enrollee at the treating facility prevails and is binding on the Contractor (42 CFR 438.114 (d)(3)).

3.5.2 Post-stabilization Services: Post-stabilization services are defined herein.

3.5.2.1 The Contractor will provide all inpatient and outpatient post-stabilization services in accord with the requirements of 42 CFR 438.114 and 42 CFR 422.113(c).

3.5.2.2 The Contractor shall cover all post-stabilization services provided by a licensed provider, acting within their scope of practice, without regard to whether the provider is a participating or non-participating provider.

3.5.2.3 The Contractor shall cover post-stabilization services under the following circumstances (42 CFR 438.114 (e) and 42 CFR 438.113(c)(2)(iii))):

3.5.2.3.1 The services are pre-approved by a participating provider or other Contractor representative.

3.5.2.3.2 The services are not pre-approved by a participating provider or other Contractor representative, but are administered to maintain the enrollee's stabilized condition within 1 hour of a request to the Contractor for pre-approval of further post-stabilization care services.

3.5.2.3.3 The services are not pre-approved by a participating provider or other Contractor representative, but are administered to maintain, improve, or resolve the enrollee's stabilized condition and:

3.5.2.3.3.1 The Contractor does not respond to a request for pre-approval within thirty (30) minutes (RCW 48.43.093(d));

3.5.2.3.3.2 The Contractor cannot be contacted; or

3.5.2.3.3.3 The Contractor representative and the treating physician cannot reach an agreement concerning the enrollee's care and a Contractor physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with care of the enrollee until a Contractor physician is reached or one of the criteria identified in 42 CFR

438.114(e) and 42 CFR 422.133(c)(3) is met.

3.5.2.3.4 The Contractorôs responsibility for post-stabilization services it has not pre-approved ends when (42 CFR 438.114(e) and 42 CFR 422.133(c)(3)):

3.5.2.3.4.1 A participating provider with privileges at the treating hospital assumes responsibility for the enrollee's care;

3.5.2.3.4.2 A participating provider assumes responsibility for the enrollee's care through transfer;

3.5.2.3.4.3 A Contractor representative and the treating physician reach an agreement concerning the enrollee's care; or

3.5.2.3.4.4 The enrollee is discharged.

4 COORDINATION OF BENEFITS (COB)

4.1 Benefits Subject To This Provision

Benefits under Basic Health shall be coordinated as prescribed in this Section.

4.2 "Plan" Defined

4.2.1 ñPlan,ò as used in this Section only, includes any of the following sources of benefits or services:

4.2.1.1 Group or blanket disability insurance policies and health care service contractor and health maintenance organization group agreements, issued by insurers, health care service contractors, and health maintenance organizations, respectively;

4.2.1.2 Labor-management trustee Plans, labor organization Plans, employer organization Plans or employee benefit organization Plans;

4.2.1.3 Governmental programs; and

4.2.1.4 Coverage required or provided by any statute.

4.2.2 ñPlanò shall be construed separately with respect to each health contract or other arrangement for benefits or services, and separately with respect to the respective portions of any such health contract or other arrangement which do and which do not reserve the right to take the benefits or services of other health contracts or other arrangements into consideration in determining its benefits.

4.3 "Allowable Expense" Defined

4.3.1 ñAllowable Expense,ò as used in this Section, means the customary and reasonable charge for any necessary health care service or supply when the service or supply is covered at least in part under any of the Plans involved. When a Plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense unless the Enrolleeôs stay in a private hospital room is considered medically necessary under at least one of the Plans involved.

4.3.2 In the case where coverage is provided through internal maximums in the contract, Contractor shall coordinate benefits in such a manner as to allow coverage for the internal maximums provided for in both the primary contract and this Exhibit. If internal maximums are provided for by a specified maximum dollar amount, then Contractor must coordinate benefits as secondary Plan until benefits under the primary contract are exhausted, then pay BH benefits (up to BH internal maximum dollar amount) until BH benefits are exhausted. If internal maximums are provided for by a specified maximum number of visits, then Contractor must coordinate benefits as secondary Plan until benefits under the primary contract are exhausted, then pay BH benefits (up to BH maximum) until BH benefits are exhausted.

4.4 "Claim Determination Period" Defined

ñClaim Determination Period,ò as used in this Section, means a calendar year.

4.5 Facility of Payment

Whenever payments which should have been made under this Exhibit in accordance with this provision have been made under any other Plan, Contractor shall have the right, exercisable alone and in its sole discretion, to pay over to any Plan making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be considered benefits paid under this Exhibit and, to the extent of such payments, Contractor shall be fully discharged from liability under this Exhibit. This provision shall not apply to the extent it conflicts with the requirements of RCW 48.44.026.

4.6 Right of Recovery

Whenever payments have been made by Contractor with respect to allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Exhibit, Contractor shall have the right to recover such payments, to the extent of such excess, from one or more of the following, as Contractor shall determine: (1) any persons to or for or with respect to whom such payments were made, (2) any other insurers, (3) any service Plans, or (4) any other organizations or other Plans.

4.7 Effect on Benefits

4.7.1 This Section shall apply in determining the benefits for a person covered under this Exhibit for a particular claim determination period if, for the

allowable expenses incurred as to such person during such period, the sum of: (1) the benefits that would be payable under this Exhibit in the absence of this provision, and (2) the benefits that would be payable under all other health Plans in the absence therein of provisions of similar purpose to this provision would exceed such allowable expenses.

4.7.2 As to any claim determination period with respect to which this Section is applicable, the benefits that would be payable under this Exhibit in the absence of this provision for the allowable expenses incurred as to such person during the applicable claim determination period shall be reduced to the extent necessary so that the sum of reduced benefits and all the benefits payable for allowable expenses under all other health Plans, except as provided elsewhere in this Section, shall not exceed the total of allowable expenses. Benefits payable under another health Plan include the benefits that would have been payable had claim been duly made therefore.

4.7.3 Except where in conflict with federal or state law, or regulations promulgated thereunder, the benefits of any other health Plan which covers the Enrollee shall be determined before the benefits of BH.

4.7.4 When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any claim determination period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.

4.8 Enrollee Cost Sharing

For the period July 1, 2012 through December 31, 2012, an Enrollee who was enrolled before July 1, 2012, will receive credit for all cost-sharing incurred for covered services incurred in calendar year 2012, if the health plan they were enrolled in before July 1, 2012 is no longer available.

5 GENERAL PROVISIONS

5.1 Termination of Enrollee Coverage

5.1.1 Enrollee coverage may be terminated by HCA in accordance with the eligibility provisions set forth in WAC 182-25-030 and as described in the COC (Exhibit B-2).

5.1.2 In the event that an Enrollee appeals a disenrollment decision through the HCA appeals process, HCA may require Contractor to continue to provide services to the Enrollee under the terms of this Contract pending the final decision. Contractor agrees to continue to provide services, provided HCA continues to pay the monthly fee to Contractor for such Enrollee according to the terms of this Contract. With prior approval of HCA, Contractor may discontinue providing services to an Enrollee during the appeals process if the Enrollee has demonstrated a danger or threat to the safety or property of the Contractor, its staff, Providers, patients, or visitors.

5.1.3 Contractor may request that HCA terminate an Enrolleeôs coverage for repeated; abuse, intentional misconduct, danger or threat to the safety of the Contractor, its staff, Providers, patients, or visitors.

5.1.4 Prior to requesting disenrollment for abuse, intentional misconduct, or posing an imminent danger or threat, Contractor shall validate Contractor's Medical Director has reviewed the circumstances to ensure the Enrollee has been appropriately evaluated and offered all appropriate Covered Services.

5.1.5 HCA will not terminate enrollment of an enrollee solely due to a request based on an adverse change in the enrollee's health status, the cost of meeting the enrollee's health care needs, because of the enrollee's utilization of medical services, diminished mental capacity, uncooperative or disruptive behavior resulting from their special needs or treatable mental health condition (WAC 182-538-130 and 42 CFR 438.56(b)(2)).

5.1.6 The Contractor must give the Enrollee written notice of its intent to request the Enrollee's termination of enrollment with the Contractor, unless the requirement for notification has been waived by the Health Care Authority because the Enrollee's conduct presents the threat of imminent harm to others. The Contractor's notice to the Enrollee shall include the Enrollee's right to use the Contractor's grievance process to review the request to end the Enrollee's enrollment.

5.1.7 If an Enrollee is confined in a hospital or skilled nursing facility for which benefits are provided when Basic Health coverage ends and the Enrollee is not immediately covered by other health care coverage, benefits will be extended until the earliest of the following events: (1) the Enrollee is discharged from the hospital or from a hospital to which the Enrollee is directly transferred; (2) the Enrollee is discharged from a skilled nursing facility when directly transferred from a hospital when the skilled nursing facility confinement is in lieu of hospitalization; (3) the Enrollee is discharged from the skilled nursing facility or from a skilled nursing facility to which the Enrollee is directly transferred; (4) the Enrollee is covered by another health plan which will provide benefits for the services; or (5) benefits are exhausted.

Rate Confirmation -- Basic Health July 2012 - December 2013 Capitation Rates

Contractor: UnitedHealthcare Community Plan

	Subsidized BH				
Age Factors	0.44	0.79	1.00	1.71	2.16
County	Child 19-25	Adult 19-39	Adult 40-54	Adult 55-64	Adult 65+
Adams	$ 81.10	$ 145.61	$ 184.32	$ 315.19	$ 398.13
Asotin	$ 101.38	$ 182.02	$ 230.40	$ 393.98	$ 497.66
Benton	$ 81.10	$ 145.61	$ 184.32	$ 315.19	$ 398.13
Chelan	$ 94.62	$ 169.88	$ 215.04	$ 367.72	$ 464.49
Clallam	$ 117.15	$ 210.33	$ 266.24	$ 455.27	$ 575.08
Clark	-	-	-	-	-
Columbia	$ 117.15	$ 210.33	$ 266.24	$ 455.27	$ 575.08
Cowlitz	$ 101.38	$ 182.02	$ 230.40	$ 393.98	$ 497.66
Douglas	$ 94.62	$ 169.88	$ 215.04	$ 367.72	$ 464.49
Ferry	$ 94.62	$ 169.88	$ 215.04	$ 367.72	$ 464.49
Franklin	$ 94.62	$ 169.88	$ 215.04	$ 367.72	$ 464.49
Garfield	$ 117.15	$ 210.33	$ 266.24	$ 455.27	$ 575.08
Grant	$ 81.10	$ 145.61	$ 184.32	$ 315.19	$ 398.13
Grays Harbor	$ 101.38	$ 182.02	$ 230.40	$ 393.98	$ 497.66
Island	$ 101.38	$ 182.02	$ 230.40	$ 393.98	$ 497.66
Jefferson	$ 101.38	$ 182.02	$ 230.40	$ 393.98	$ 497.66
King	$ 94.62	$ 169.88	$ 215.04	$ 367.72	$ 464.49
Kitsap	$ 94.62	$ 169.88	$ 215.04	$ 367.72	$ 464.49
Kittitas	$ 81.10	$ 145.61	$ 184.32	$ 315.19	$ 398.13
Klickitat	$ 117.15	$ 210.33	$ 266.24	$ 455.27	$ 575.08
Lewis	$ 94.62	$ 169.88	$ 215.04	$ 367.72	$ 464.49
Lincoln	$ 81.10	$ 145.61	$ 184.32	$ 315.19	$ 398.13
Mason	$ 126.16	$ 226.51	$ 286.72	$ 490.29	$ 619.32
Okanogan	$ 81.10	$ 145.61	$ 184.32	$ 315.19	$ 398.13
Pacific	$ 117.15	$ 210.33	$ 266.24	$ 455.27	$ 575.08
Pend Oreille	$ 94.62	$ 169.88	$ 215.04	$ 367.72	$ 464.49
Pierce	$ 94.62	$ 169.88	$ 215.04	$ 367.72	$ 464.49
San Juan	$ 81.10	$ 145.61	$ 184.32	$ 315.19	$ 398.13
Skagit	$ 101.38	$ 182.02	$ 230.40	$ 393.98	$ 497.66
Skamania	$ 94.62	$ 169.88	$ 215.04	$ 367.72	$ 464.49
Snohomish	$ 101.38	$ 182.02	$ 230.40	$ 393.98	$ 497.66
Spokane	$ 94.62	$ 169.88	$ 215.04	$ 367.72	$ 464.49
Stevens	$ 94.62	$ 169.88	$ 215.04	$ 367.72	$ 464.49
Thurston	$ 94.62	$ 169.88	$ 215.04	$ 367.72	$ 464.49
Wahkiakum	$ 126.16	$ 226.51	$ 286.72	$ 490.29	$ 619.32
Walla Walla	$ 81.10	$ 145.61	$ 184.32	$ 315.19	$ 398.13
Whatcom	$ 101.38	$ 182.02	$ 230.40	$ 393.98	$ 497.66
Whitman	$ 94.62	$ 169.88	$ 215.04	$ 367.72	$ 464.49
Yakima	$ 94.62	$ 169.88	$ 215.04	$ 367.72	$ 464.49

	HCTC BH				
	0.44	0.79	1.00	1.71	2.16
	One child	Adult 0-39	Adult 40-54	Adult 55-64	Adult 65+
Adams	$ 82.76	$ 148.58	$ 188.08	$ 321.62	$ 406.25
Asotin	$103.44	$ 185.73	$ 235.10	$ 402.02	$ 507.82
Benton	$ 82.76	$ 148.58	$ 188.08	$ 321.62	$ 406.25
Chelan	$ 96.55	$ 173.35	$ 219.43	$ 375.23	$ 473.97
Clallam	$119.53	$ 214.62	$ 271.67	$ 464.56	$ 586.81
Clark	-	-	-	-	-
Columbia	$119.53	$ 214.62	$ 271.67	$ 464.56	$ 586.81
Cowlitz	$103.44	$ 185.73	$ 235.10	$ 402.02	$ 507.82
Douglas	$ 96.55	$ 173.35	$ 219.43	$ 375.23	$ 473.97
Ferry	$ 96.55	$ 173.35	$ 219.43	$ 375.23	$ 473.97
Franklin	$ 96.55	$ 173.35	$ 219.43	$ 375.23	$ 473.97
Garfield	$119.53	$ 214.62	$ 271.67	$ 464.56	$ 586.81
Grant	$ 82.76	$ 148.58	$ 188.08	$ 321.62	$ 406.25
Grays Harbor	$103.44	$ 185.73	$ 235.10	$ 402.02	$ 507.82
Island	$103.44	$ 185.73	$ 235.10	$ 402.02	$ 507.82
Jefferson	$103.44	$ 185.73	$ 235.10	$ 402.02	$ 507.82
King	$ 96.55	$ 173.35	$ 219.43	$ 375.23	$ 473.97
Kitsap	$ 96.55	$ 173.35	$ 219.43	$ 375.23	$ 473.97
Kittitas	$ 82.76	$ 148.58	$ 188.08	$ 321.62	$ 406.25
Klickitat	$119.53	$ 214.62	$ 271.67	$ 464.56	$ 586.81
Lewis	$ 96.55	$ 173.35	$ 219.43	$ 375.23	$ 473.97
Lincoln	$ 82.76	$ 148.58	$ 188.08	$ 321.62	$ 406.25
Mason	$128.73	$ 231.13	$ 292.57	$ 500.29	$ 631.95
Okanogan	$ 82.76	$ 148.58	$ 188.08	$ 321.62	$ 406.25
Pacific	$119.53	$ 214.62	$ 271.67	$ 464.56	$ 586.81
Pend Oreille	$ 96.55	$ 173.35	$ 219.43	$ 375.23	$ 473.97
Pierce	$ 96.55	$ 173.35	$ 219.43	$ 375.23	$ 473.97
San Juan	$ 82.76	$ 148.58	$ 188.08	$ 321.62	$ 406.25
Skagit	$103.44	$ 185.73	$ 235.10	$ 402.02	$ 507.82
Skamania	$ 96.55	$ 173.35	$ 219.43	$ 375.23	$ 473.97
Snohomish	$103.44	$ 185.73	$ 235.10	$ 402.02	$ 507.82
Spokane	$ 96.55	$ 173.35	$ 219.43	$ 375.23	$ 473.97
Stevens	$ 96.55	$ 173.35	$ 219.43	$ 375.23	$ 473.97
Thurston	$ 96.55	$ 173.35	$ 219.43	$ 375.23	$ 473.97
Wahkiakum	$128.73	$ 231.13	$ 292.57	$ 500.29	$ 631.95
Walla Walla	$ 82.76	$ 148.58	$ 188.08	$ 321.62	$ 406.25
Whatcom	$103.44	$ 185.73	$ 235.10	$ 402.02	$ 507.82
Whitman	$ 96.55	$ 173.35	$ 219.43	$ 375.23	$ 473.97
Yakima	$ 96.55	$ 173.35	$ 219.43	$ 375.23	$ 473.97

	AI/AN BH				
	0.44	0.79	1.00	1.71	2.16
	One child	Adult 0-39	Adult 40-54	Adult 55-64	Adult 65+
Adams	$109.74	$ 197.03	$ 249.40	$ 426.47	$ 538.70
Asotin	$130.01	$ 233.43	$ 295.48	$ 505.27	$ 638.24
Benton	$109.74	$ 197.03	$ 249.40	$ 426.47	$ 538.70
Chelan	$123.25	$ 221.29	$ 280.12	$ 479.01	$ 605.06
Clallam	$145.78	$ 261.74	$ 331.32	$ 566.56	$ 715.65
Clark	-	-	-	-	-
Columbia	$145.78	$ 261.74	$ 331.32	$ 566.56	$ 715.65
Cowlitz	$130.01	$ 233.43	$ 295.48	$ 505.27	$ 638.24
Douglas	$123.25	$ 221.29	$ 280.12	$ 479.01	$ 605.06
Ferry	$123.25	$ 221.29	$ 280.12	$ 479.01	$ 605.06
Franklin	$123.25	$ 221.29	$ 280.12	$ 479.01	$ 605.06
Garfield	$145.78	$ 261.74	$ 331.32	$ 566.56	$ 715.65
Grant	$109.74	$ 197.03	$ 249.40	$ 426.47	$ 538.70
Grays Harbor	$130.01	$ 233.43	$ 295.48	$ 505.27	$ 638.24
Island	$130.01	$ 233.43	$ 295.48	$ 505.27	$ 638.24
Jefferson	$130.01	$ 233.43	$ 295.48	$ 505.27	$ 638.24
King	$123.25	$ 221.29	$ 280.12	$ 479.01	$ 605.06
Kitsap	$123.25	$ 221.29	$ 280.12	$ 479.01	$ 605.06
Kittitas	$109.74	$ 197.03	$ 249.40	$ 426.47	$ 538.70
Klickitat	$145.78	$ 261.74	$ 331.32	$ 566.56	$ 715.65
Lewis	$123.25	$ 221.29	$ 280.12	$ 479.01	$ 605.06
Lincoln	$109.74	$ 197.03	$ 249.40	$ 426.47	$ 538.70
Mason	$154.79	$ 277.92	$ 351.80	$ 601.58	$ 759.89
Okanogan	$109.74	$ 197.03	$ 249.40	$ 426.47	$ 538.70
Pacific	$145.78	$ 261.74	$ 331.32	$ 566.56	$ 715.65
Pend Oreille	$123.25	$ 221.29	$ 280.12	$ 479.01	$ 605.06
Pierce	$123.25	$ 221.29	$ 280.12	$ 479.01	$ 605.06
San Juan	$109.74	$ 197.03	$ 249.40	$ 426.47	$ 538.70
Skagit	$130.01	$ 233.43	$ 295.48	$ 505.27	$ 638.24
Skamania	$123.25	$ 221.29	$ 280.12	$ 479.01	$ 605.06
Snohomish	$130.01	$ 233.43	$ 295.48	$ 505.27	$ 638.24
Spokane	$123.25	$ 221.29	$ 280.12	$ 479.01	$ 605.06
Stevens	$123.25	$ 221.29	$ 280.12	$ 479.01	$ 605.06
Thurston	$123.25	$ 221.29	$ 280.12	$ 479.01	$ 605.06
Wahkiakum	$154.79	$ 277.92	$ 351.80	$ 601.58	$ 759.89
Walla Walla	$109.74	$ 197.03	$ 249.40	$ 426.47	$ 538.70
Whatcom	$130.01	$ 233.43	$ 295.48	$ 505.27	$ 638.24
Whitman	$123.25	$ 221.29	$ 280.12	$ 479.01	$ 605.06
Yakima	$123.25	$ 221.29	$ 280.12	$ 479.01	$ 605.06

Keep this book handy for quick reference.

Exhibit B-2

Basic Health™

2012 Member Handbook

Effective July 1, 2012 - December 31, 2012

Note: **If you are enrolled in Basic Health through the federal Health Coverage Tax Credit (HCTC) program, Appendix B of this handbook (and information referenced there) applies to you.**

Basic Health™

Basic Health ID # _____

Health plan ID # _____

Health plan phone # _____

Basic Health: Mon.-Fri. 8 a.m.-5p.m. 1-800-660-9840

TTY users may call this number through the Washington Relay Service by dialing 711.

HCA 22-405 (7/12)

Contact Information

	Customer Service Hours	Customer Service Phone Numbers	Website Address
Basic Health	Mon. – Fri. 8 a.m. – 5 p.m.	1-800-660-9840 TTY: 7-1-1	www.basichealth.hca.wa.gov
Internal Revenue Service (to request federal income tax information)	Mon. – Fri.	1-800-829-1040	www.irs.gov
Health Coverage Tax Credit (HCTC) Program	Mon. – Fri. 5 a.m. – 5 p.m.	1-866-628-4282 TTY: 1-866-626-4282	www.irs.gov (Keyword: HCTC)
Amerigroup	Mon. – Fri. 8 a.m. – 5 p.m.	1-800-600-4441	www.amerigroup.com
Community Health Plan of Washington	Mon. – Fri. 8 a.m. – 5 p.m.	1-800-440-1561 TTY: 7-1-1	www.chpw.org
Coordinated Care Corporation	Mon. – Fri. 8 a.m. – 5 p.m.	1-877-644-4613	www.coordinatedcarehealth.com
Molina Healthcare of Washington, Inc.	Mon. – Fri. 8 a.m. – 5 p.m.	1-800-869-7165 TTY: 1-877-665-4629	www.molinahealthcare.com
UnitedHealthcare Community Plan	Mon. – Fri. 8 a.m. – 8 p.m.	1-877-542-8997	www.uhcommunityplan.com

Premium payments are due by the 5th day of the month before the actual month of coverage; the amount and due date are shown on each month's bill. Your bill is sent about six weeks before the month to be covered by that payment. For example, the bill for August coverage is sent mid-June and payment is due July 5.

Basic Health	Mailing Addresses
Premium payments	P.O. Box 34270, Seattle, WA 98124-1270
General correspondence	P.O. Box 42683, Olympia, WA 98504-2683
Basic Health appeals (see page 18)	P.O. Box 42690, Olympia, WA 98504-2690

If you have any questions about...	Contact...
• **Adding and/or dropping coverage** • **Address changes** • **Income changes** • **Your monthly premium** • **Your bill from Basic Health** • **Refunds**	Basic Health at 1-800-660-9840 to talk to a Basic Health representative or go to **www.basichealth.hca.wa.gov.**
• **A bill for medical care** • **Choosing a provider** • **Covered services** • **Services received from providers** • **Waiting period**	Your health plan. (See the phone number on the previous page.)
• **Your medical care** • **Referrals to specialists**	Your primary care provider.

When you call or write to us...

Include your name, Basic Health ID number, address, and a daytime phone number. Be sure to note the date of the call, the name of the person you talked to, and the organization you contacted. If you have Basic Health through your employer, a home care agency, or a financial sponsor, first contact your representative (usually your payroll officer or financial sponsor representative). Your representative may have the information you need, or may need to know about the change you're making.

To obtain this document in another format (such as Braille or audio), call 1-800-660-9840. TTY users may call this number through the Washington Relay Service by dialing 711.

Keep *Member Alerts* and other updates here

Member Alerts are important updates to this Member Handbook and are one way Basic Health provides you with official notice of program changes; you will receive them periodically, usually with your monthly billing statement. Keep these updates handy, along with this Member Handbook and other information you receive from Basic Health, so that you have the information you need to make the most of your Basic Health coverage.

Table of Contents

(continued)

Table of Contents *(continued)*

Introduction

Basic Health offers quality, low-cost health coverage to eligible people who live in Washington State. It is a state program managed by the Washington State Health Care Authority (HCA). The HCA contracts with health plans to offer Basic Health and Basic Health Plus coverage. Each health plan works with hospitals, clinics, pharmacies, physicians, and other providers to serve Basic Health and Basic Health Plus members.

If any of your family members are enrolled in Basic Health Plus or the Maternity Benefits Program, you should have received A Guide to Basic Health Plus and the Maternity Benefits Program, with specific information about these programs. If you have not received this guide, call Basic Health at 1-800-660-9840.

You must give Basic Health the information needed to determine your continued eligibility for the program. You must also give your health plan all the information it needs to process claims, including medical records.

You must follow your health plan's rules to get the benefits described in this handbook. Rules may be different between health plans. Be sure to read your health plan's materials for details, and call the plan if you have questions about your benefits.

This handbook is your "certificate of coverage." It describes what Basic Health covers, what it doesn't cover, and the rules you must follow when using your coverage. This handbook is subject to State laws and rules governing Basic Health (Chapters 70.47 RCW and 182-22, 182-24, 182-25 WAC). If there are any conflicts between this handbook and the law or rule, the law or rule governs.

Keep this Member Handbook handy, and look at it when you have a question about your benefits. Basic Health may send other important documents, such as Member Alerts and open enrollment materials. These may include updates to this handbook. Always keep them with your Member Handbook.

If you are enrolled in Basic Health as a Health Coverage Tax Credit (HCTC) enrollee, first read Appendix B of this handbook, starting on page 36.

Throughout this handbook, "you" generally refers to the main subscriber on the Basic Health account or to an adult who will be reading and referring to coverage information on behalf of an enrolled dependent.

Chapter One:
Eligibility for Basic Health Programs

To be eligible for subsidized Basic Health you must:

- Be a Washington State resident;
- Be a US Citizen or qualified non-citizen;
- Be between 19 and 64 years old;
- Have gross family income at or below 200% of the Federal Income Guidelines;
- Have countable family income between 0-133% of the Federal Income Guidelines;
- Not be eligible for or receiving Medicaid or other medical assistance adminstered by the Health Care Authority;
- Not be eligible for free or purchased Medicare;
- Not be a full-time student who has received a temporary visa to study in the United States;
- Not be institutionalized at the time of enrollment; and
- Not be enrolled in the Washington Health Program.

Specific programs may have additional eligibility requirements. Basic Health is also available to people eligible for the Health Coverage Tax Credit through the Internal Revenue Service (IRS), whether or not they meet the above criteria.

Family members who should be listed as dependents on your account (even if they are not enrolling for coverage) include:

- Your spouse living in the same house and not legally separated from you.
- Your child, under age 26, including stepchild, legally adopted child, and a child placed in your home for purposes of adoption or under your legal guardianship, who is under age 26.
- A child in your custody under an informal guardianship agreement that is signed by the child's parent(s) and allows you to get medical care for the child. You must provide a copy of the guardianship agreement and proof that you are providing at least 50 percent of the child's support. You cannot list a child who is in your home under a foster care agreement.
- Your child, stepchild, legally adopted child, or legal dependent of any age who cannot take care of him- or herself due to disability. You must provide proof of disability. If the dependent with a disability is not your birth or adopted child, you must also provide proof of legal guardianship.

Family members who are not eligible for coverage on your account may be able to enroll separately. For example, a child who reaches age 26 and is not disabled. This family member must complete a separate Basic Health application.

Family enrollment

Individuals may apply for Basic Health, Basic Health Plus, the Maternity Benefits Program, or other programs for themselves and qualified family members. You and your family members may be enrolled in different programs. For example, you may enroll in Basic Health, your spouse in the Maternity Benefits Program, and your child in Basic Health Plus.

Premiums

Premium payments are due by the 5th day of each month before the actual month of coverage; the amount and due date are shown on each month's bill. We will send you a bill about six weeks before the month to be covered by that payment. For example, the bill for August's coverage is sent mid-June and payment is due July 5.

If the entire premium is not paid on time, Basic Health will send you a late notice. This notice will include the bill for both the past due amount (called the delinquent balance) and the premium for the following month's coverage. Basic Health must receive payment for each amount due by the

due date given, or your coverage will be suspended for one month. Partial payment or checks that cannot be processed (for example, insufficient funds or missing a signature) will be considered nonpayment and may cause you to lose coverage. For more information, refer to page 12.

Basic Health *Plus*

This Health Care Authority (HCA) program is for children under age 19. With Basic Health Plus, children receive additional health care coverage such as dental care, vision care, and physical therapy. Children enrolled in Basic Health Plus receive services through the same health plan that provides your Basic Health coverage.

Your family will have to meet the Basic Health Plus income guidelines, available at **http://hrsa.dshs.wa.gov/Eligibility/0VERVIEW/MedicalOverview.htm**. The children must be your legal dependents, live in your home, and:

- Be under age 19.
- Be U.S. citizens, or immigrants who have legally lived in the U.S. for five years.
- Not be enrolled in any other managed care plan, including TRICARE.
- Not be receiving Temporary Assistance for Needy Families (TANF) grants from the Department of Social and Health Services.

For some Basic Health Plus services, such as dental and vision care, the state pays the provider directly.

If you would like to transfer your child's coverage from Basic Health to Basic Health Plus, call 1-800-660-9840 or visit our website **(www.basichealth.hca.wa.gov)** to request a Basic Health Plus application.

Maternity Benefits Program

This HCA program provides pregnant women with full maternity coverage, usually through the same providers and health plan chosen for Basic Health coverage. See pages 22-23 for more information on maternity coverage.

Basic Health for personal care workers

If you are working for DSHS as a personal care worker, and meet Basic Health income guidelines, you may be able to pay even less for Basic Health coverage.

For more information or to request a personal care worker application, call 1-800-660-9840 or check Basic Health's website.

Basic Health for foster parents

If you have a current foster parent license issued by DSHS, you may be eligible for lower premium rates through our foster parent program. For information or to request a foster parent application call 1-800-660-9840 or visit our website.

The licensed foster parents in your family may qualify for coverage even if they exceed income limits for Basic Health. See chart on page 5 for income guidelines.

Basic Health through your employer, financial sponsor, or home care agency

Employers, home care agencies, and financial sponsors may enroll their employees or sponsored members in Basic Health. Your employer or sponsor pays your premium, but may collect part of it from you. Your main contact with Basic Health will be through your employer or sponsor.

If your employer, home care agency, or financial sponsor doesn't pay the premium on time, or if you no longer qualify for coverage through them, you may be disenrolled. If your entire organization is disenrolled, Basic Health will offer you individual coverage; however, you may have a break in coverage.

Health Coverage Tax Credit

If you are enrolled in Basic Health through the federal Health Coverage Tax Credit (HCTC) program, please read Appendix B of this handbook. If you are not enrolled in HCTC-Basic Health, but think you may qualify, call 1-866-628-4282, or visit **www.irs.gov** (keyword: HCTC).

Chapter Two:
Income Guidelines

To be eligible for Basic Health and to receive a subsidy for your monthly premium, BH will look at your income in two ways.

To be eligible for Basic Health, your family's countable income must be at or below 133% of the Federal Income Guidelines (FIG). We use the following process to determine your family's countable income:

> ((Wages + Net Self-Employment) - Earned Income Disregard) + Unearned Income - Deductions = Countable Income

If your family's countable income is at or below 133% of the FIG, we will then determine whether or not you are eligible to receive a subsidy, and if so, how much.

See page 5 for definitions, an income table, and an example on countable income.

To receive a subsidy, your family's gross income must be at or below 200% of the FIG. We will use your gross family income to determine your share of your monthly premium. For more information on gross family income, see the Gross Income Table on page 6.

How your income is calculated

Basic Health requires current pay stubs and a copy of your IRS Form 1040 for the most recent tax year, with all schedules filed. We will look at your income from both sources and use the one that gives the best picture of your income.

If you cannot provide IRS documentation (you were not required to file a tax return), we will use your most recent income documentation, unless your income is seasonal. If Basic Health determines your income is seasonal, we will use an average of your income over several months. We may require you to provide additional documents.

If you are reporting self-employment or rental income, Basic Health will use a 12-month average of that income, unless you have had the business or rental property for less than 12 months. When figuring your self-employment income, Basic Health will not deduct depreciation or amortization, and may not deduct business use of your home. A net loss from this calculation will not be used to offset other income sources (a loss equals zero).

If you paid for childcare or for the care of a disabled dependent so either you or your spouse could work or go to school, you may be allowed to deduct expenses, up to a maximum of $1,025 per month per child or disabled dependent. We require proof showing the amount you paid and to whom. (This will not count if paid to the child's parent or stepparent, or to another dependent of the main subscriber.) If the expenses were for the care of a disabled dependent, we will require you to provide documents proving the disability and, if the care is during school hours, that they cannot attend public schools.

The table on page 6 shows the income bands used for determining eligibility and your family's monthly premiums through June 2013. After June 30, 2013, please call 1-800-660-9840 or check our website **(www.basichealth.hca.wa.gov)** for information. To find your income band, find your family size and your family's gross monthly income (before taxes and other deductions).

See Appendix B for information on HCTC.

Income Definitions

Wages	Gross wages for both subscriber and spouse
Net Self-Employment Income	Business related income and expenses from self-employment or rental income
Earned Income Disregard	Fifty percent of the combined wages and net self-employment ((Wages + Net Self-Employment) x 50%)
Unearned Income	Other income listed for Subscriber and Spouse only
Deduction(s)	Child care expenses up to $1,025 per month per eligible dependent

Countable Income Table

Family Size	133% Countable Monthly Income Max	133% Countable Yearly Income Max
1	~~$1,207~~	~~$14,484~~
2	~~$1,630~~	~~$19,564~~
3	~~$2,054~~	~~$24,645~~
4	~~$2,477~~	~~$29,726~~
5	~~$2,901~~	~~$34,806~~
6	~~$3,324~~	~~$39,887~~
7	~~$3,747~~	~~$44,967~~

Source = 2011 Federal Register Vol. 76, No. 13, January 20, 2011, pp. 3637-3638

Countable Income Example

A family of three with gross monthly wages of $2,600, gross monthly unearned income of $200, and child care expenses of $500 monthly has a countable income of $1,000 monthly.

$2,600	Gross Wages
-$1,300	Less Earned Income Disregard
$1,300	Sub Total
+$200	Plus Unearned Income
$1,500	Sub Total
-$500	Less Childcare Expenses
$1,000	Total Countable Income

<Table to be updated before July 1, 2012>

See Appendix B for information on HCTC.

Gross Income Table

Gross Monthly Income	Number of People in Your Family							Income Band
	1	2	3	4	5	6	7	
	~~$0 – $589.87~~	~~$0 – $796.79~~	~~$0 – $1,003.70~~	~~$0 – $1,210.62~~	~~$0 – $1,417.54~~	~~$0 – $1,624.45~~	~~$0 – $1,831.37~~	A
	~~589.88 – 907.49~~	~~796.80 – 1,225.83~~	~~1,003.71 – 1,544.16~~	~~1,210.63 – 1,862.49~~	~~1,417.55 – 2,180.83~~	~~1,624.46 – 2,499.16~~	~~1,831.38 – 2,817.49~~	B
	~~907.50 – 1,134.37~~	~~1,225.84 – 1,532.29~~	~~1,544.17 – 1,930.20~~	~~1,862.50 – 2,328.12~~	~~2,180.84 – 2,726.04~~	~~2,499.17 – 3,123.95~~	~~2,817.50 – 3,521.87~~	C
	~~1,134.38 – 1,270.49~~	~~1,532.30 – 1,716.16~~	~~1,930.21 – 2,161.83~~	~~2,328.13 – 2,607.49~~	~~2,726.05 – 3,053.16~~	~~3,123.96 – 3,498.83~~	~~3,521.88 – 3,944.49~~	D
	~~1,270.50 – 1,406.62~~	~~1,716.17 – 1,900.04~~	~~2,161.84 – 2,393.45~~	~~2,607.50 – 2,886.87~~	~~3,053.17 – 3,380.29~~	~~3,498.84 – 3,873.70~~	~~3,944.50 – 4,367.12~~	E
	~~1,406.63 – 1,542.74~~	~~1,900.05 – 2,083.91~~	~~2,393.46 – 2,625.08~~	~~2,886.88 – 3,166.24~~	~~3,380.30 – 3,707.41~~	~~3,873.71 – 4,248.58~~	~~4,367.13 – 4,789.74~~	F
	~~1,542.75 – 1,678.87~~	~~2,083.92 – 2,267.79~~	~~2,625.09 – 2,856.70~~	~~3,166.25 – 3,445.62~~	~~3,707.42 – 4,034.54~~	~~4,248.59 – 4,623.45~~	~~4,789.75 – 5,212.37~~	G
	~~1,678.88 – 1,815.09~~	~~2,267.80 – 2,451.78~~	~~2,856.71 – 3,088.48~~	~~3,445.63 – 3,725.18~~	~~4,034.55 – 4,361.88~~	~~4,623.46 – 4,998.58~~	~~5,212.38 – 5,635.28~~	H
	~~**Foster Parent Income Limits***~~							
	~~1,815.10 – 2,268.84~~	~~2,451.79 – 3,064.70~~	~~3,088.49 – 3,860.57~~	~~3,725.19 – 4,656.43~~	~~4,361.89 – 5,452.30~~	~~4,998.59 – 6,248.16~~	~~5,635.29 – 7,044.03~~	I
	~~2,268.85 – 2,722.59~~	~~3,064.71 – 3,677.62~~	~~3,860.58 – 4,632.65~~	~~4,656.44 – 5,587.68~~	~~5,452.31 – 6,542.71~~	~~6,248.17 – 7,497.74~~	~~7,044.04 – 8,452.78~~	J

*I & J apply only to licensed Foster Parents

Valid through June 30, 2013

<Table to be updated before July 1, 2012>

See Appendix B for information on HCTC.

Chapter Three: Making Changes and Maintaining Eligibility

Changes to your account could affect your Basic Health coverage. Report changes to Basic Health within the timelines noted in this chapter. You may use the Change Form included with your monthly bill to make some account changes. To get other forms, call 1-800-660-9840 or visit our website. You may also write to Basic Health at the address shown on page ii.

If you are enrolled through your employer or a financial sponsor, make sure the sponsor knows about changes in your income or family, too, because it may affect the amount you pay for your coverage. Contact your financial sponsor, employer, or payroll office if you have questions.

Changing health plans

Open enrollment is the time each year when you can change your health plan (if there is more than one plan available in your area), except as noted elsewhere in this section. During open enrollment, Basic Health will send you information about any changes to your coverage, and will tell you about health plans in your area and their monthly premiums. Basic Health will notify you before each open enrollment and give you instructions for making changes.

Other than during open enrollment, you may only change health plans under certain conditions. These are explained later in this chapter. You cannot change health plans because your provider is no longer with your health plan. (An exception may be made in some cases if you can prove that you need to continue a current course of treatment with a specific provider.) When you change health plans, remember each health plan contracts with different providers and has its own list of prescription drugs. Call the health plan or your provider to find out if your provider contracts with the health plan you are considering. If you take any prescription drugs, contact the health plan to see if they will be covered.

If you change health plans, any services you had approved under your previous health plan will need to be reviewed and approved again by your new health plan. Also, your deductible and out-of-pocket maximum will start over. Check with your health plan for further information.

Basic Health will do its best to make sure your health plan is available throughout the year. However, if your health plan becomes unavailable, you will be asked to choose one of the plans in your county. If only one health plan remains, you will be assigned to that plan.

You may also change your health plan if the Health Care Authority (HCA) imposes an indeterminate sanction(s) on your health plan, but only if another health plan is available in the service area where you live. If this occurs, Basic Health will notify you. You may not be required to change health plans, but if you choose to do so, Basic Health will assist you with the change in health plans. If you are allowed to change health plans because the HCA has imposed a sanction on your health plan, your yearly deductible and out-of-pocket maximum will not start over.

Address changes

You must give Basic Health your new address within 30 days of a change. You may call Basic Health at 1-800-660-9840, complete and return the Change

See Appendix B for information on HCTC.

Form included with your bill, or write to Basic Health at PO Box 42683, Olympia, WA 98504-2683. Include your Basic Health ID number, your name, new address and county, your old address, and your new phone number. Be sure to say if your new address is permanent or temporary (less than three months), and if your mailing address is different from your street address.

If you move out of Washington State, you will be disenrolled from Basic Health. If you move out of your health plan's service area, you will have to select a new health plan. If your current health plan is still available to you, but would cost more, or you have plan choices that weren't available before you moved, you may request a plan change. While you are waiting to be transferred to your new health plan, you will need to keep using your old health plan for everything except emergency services. When you change health plans, your deductible and out-of-pocket maximum will start over.

Please note: Basic Health double-checks addresses with the U.S. Postal Service, so be sure to file any change of address with your post office.

Dependent living away from home

If your dependent is living away from home, as described below, Basic Health will cover only emergency care while the dependent is out-of-state or staying in a county that is not served by your health plan. Routine services should be scheduled when the dependent is home.

Out-of-county

If your child lives in a different county, you may be able to choose a health plan that provides service to both your home county and the county where the dependent lives. When necessary, Basic Health allows your dependent to enroll in a different health plan under a separate account so the dependent may receive services in the county where the dependent lives. You will be sent a separate bill for their account.

Out-of-state

If your child is a Washington State resident, but lives away from home part of the time (to attend college, for example), they may be eligible to receive Basic Health coverage as long as they remain a Washington State resident and return to Washington State during scheduled breaks. You may be required to provide proof of out-of-state tuition or that the child's residence is in Washington State.

Family changes

Eligible family members may enroll in Basic Health during open enrollment. You will get information telling you how to enroll a family member at that time.

Family members may be added, removed, or enrolled at other times during the year, based on the guidelines below, by completing and submitting a Family Changes Form. Adding, enrolling, or removing a family member may change your monthly premium. Basic Health will send you written confirmation of any changes to your account. Also, if the number of family members living in your home goes down, you may no longer be eligible for Basic Health.

If you do not report changes to your account in the required timeframe, you may be disenrolled. To make any family changes to your account, call 1-800-660-9840 or visit Basic Health's website to request the Family Changes Form. When you notify Basic Health of a change in family size (such as birth, marriage, divorce, or death), you will be required to submit proof of your current income and Washington State residence.

- Loss of or transfer from other continuous coverage: If you or a family member either left or chose not to enroll in Basic Health coverage because you or they had other health care coverage, and then that person loses or wants to transfer from that coverage, the request must be received by Basic Health within 30 days of the loss of coverage. You must show proof of the other continuous coverage.
- Enrolling a new family member: To enroll a new spouse, child, or dependent between 19 and 26, Basic Health must receive the appropriate application within the timeframes below. Otherwise, the family member will be counted for family size when figuring your monthly premium, but will not have coverage.
  - Marriage: Within 30 days of the date of your marriage.
  - Newborn or newly adopted child: Within 60 days of the birth or placement for adoption.

See Appendix B for information on HCTC.

  - Other dependents (children ages 19-26, adults with disabilities): Within 30 days of the date they become your dependent or move into your home. See page 2 for details.
- Removing a family member: Basic Health needs notice of the following changes within the required timeframes.
  - Divorce or separation: You must notify Basic Health within 30 days of the divorce or separation. If you get back together and are living in the same home, you must tell Basic Health, in writing, and we will stop the separation of your account.
  - Transfer of a dependent to separate account: You must notify Basic Health within 30 days of the date the person is no longer your dependent. A former dependent who is taken off the parents' account may apply for coverage on a separate account.

When coverage begins for added family members

If you get married and follow the procedures explained in "Family changes" (above), coverage for your new family members will begin on the first day of the month after eligibility has been determined and full payment is received.

Your newborn or adopted child is covered from the date of birth or placement in your home if you or a family member is enrolled in Basic Health or Basic Health Plus, and if Basic Health receives the application for the child within 60 days of the birth or placement. If Basic Health receives your application more than 60 days after the child's birth or placement, your child will be included for family size only when calculating your premium (this usually reduces your premium), but will not have medical coverage. See page 8 for more information.

Income changes

If your income changes, your monthly premium or eligibility for Basic Health may change, too. You must report any income change to Basic Health within 30 days of the end of the first month at the new income. You must continue paying your premium as billed until we tell you the new premium amount. (See additional information on pages 10-11.)

If you begin receiving Social Security Disability Benefits, you must notify Basic Health immediately. This may affect your eligibility for Basic Health.

When sending income information to Basic Health, use the list below. If this list changes, we will send you an update. Keep all updates with this handbook.

Include proof of all income received from the following sources:

- Salaries, wages, commissions, tips, work-study, training stipends, or assistantships, including overtime and bonuses
- Self-employment
- Rental property
- Unemployment
- Strike benefits
- Social Security retirement, survivor, disability, or supplemental security income (including money received by dependent children)
- Retirement and pensions
- Child support or alimony
- Insurance benefits and compensation for an injury (other than reimbursement for a loss or medical costs), including workers' compensation
- Interest, dividends, periodic receipts from a trust, and royalties
- Net short-term capital gains
- Veterans' benefits and military allotments
- Public assistance (DSHS cash assistance)
- Estate income
- Net gambling or lottery winnings, unless you received them more than one month before you apply for coverage
- All other income that's not specifically in the "Gross income does not include" list, below

Gross income does not include:

- Income, such as wages, earned by dependent children (however, you must include distributions from a corporation, partnership, or business, even if distributed to a child)
- Proceeds from the sale of personal property, such as a car

See Appendix B for information on HCTC.

- Tax refunds, gifts, or loans
- Income from a family member who lives in another household, when that income is not available to you or eligible dependents
- University scholarships, grants, VA education grants, or fellowships
- Non-cash benefits (such as food stamps, school lunches, or housing instead of wages)
- Payments for adoption support received from the Department of Social and Health Services (DSHS)
- Individual Retirement Account (IRA) distributions
- Crime victims' compensation
- L&I (Labor and Industries) one-time payments
- Long-term capital gains

Reporting income changes

Send a Family Income Reporting Form, along with proof of current income and IRS documentation for the most current tax year. You may get this form by calling 1-800-660-9840, or visiting our website. (See "Recertification" below for acceptable IRS and income documentation.)

- Include proof of childcare expenses up to $1,025 per child, if the childcare was necessary for both parents to work or attend school

Basic Health will send you a Personal Eligibility Statement. It will show any changes to your account that affect your monthly premium or eligibility for the program. It may include a bill for an additional amount you must pay as a result of the change.

Recertification

State law requires Basic Health to periodically review members' income and eligibility for this program. This is called "recertification." Under this process, Basic Health members must send in proof of income, benefits, and Washington State residency. Being selected for recertification does not mean Basic Health believes you have given us the wrong information; it is a legal requirement for all of our members. If you have to wait for Basic Health coverage because the program is full, you may be recertified soon after your coverage begins.

If you get a recertification notice, Basic Health must receive all documents requested by the due date given. Otherwise, you and your covered family members will lose your coverage for at least 12 months. If you reapply for Basic Health at the end of the 12 months, you will have to provide proof of income and eligibility at that time. Even if you are found eligible, if Basic Health is full, you will have to wait until space is available.

To complete your recertification, you must send all of the following:

- Proof that you live in Washington State.
- A copy of one of the following for the most current tax year:
  - Your IRS Form 1040 (federal income tax form) and all schedules
  - IRS transcript of your return, if you do not have a copy of your IRS Form 1040
  - A signed and dated statement declaring that you were not required to file a tax return
- Copies of pay stubs for the last 30 days for you and your spouse.
- Written proof of all other income and benefits received by your family for the last 30 days.
- If you are self-employed or have rental income, a copy of all business forms and schedules filed with the IRS, a complete copy of your Schedules K-1 (if applicable). If you were not required to file a tax return or if you have been in business for less than 12 months, you must complete and submit a Self-Employment/Rental Income Reporting Form.

We will send you more details when we select you for recertification.

What if I don't report a change in income?

We base your monthly premium in part on your income; you must report all changes in your income to Basic Health. We check with other sources to make sure this information is accurate. If we find you have not reported an income change, you must pay the difference between the premium you paid and the premium you should have paid.

See Appendix B for information on HCTC.

If this happens, Basic Health will send you a notice showing the amount we believe you owe the state. If you believe you do not owe the amount shown on that notice, you must follow the instructions in the notice. If you do not respond, or if you are unable to prove that the amount of income you reported to us was correct, Basic Health will bill you for the amount you owe.

What if I don't repay the amount I owe?

If you are billed, you must pay based on the billing schedule we provide. If you do not pay your full bill on time, you will lose your Basic Health coverage. (See page 12 for more information.) If you do not repay the total amount, your account will be sent to a collection agency and you will also have to pay any fees charged by the collection agency.

Legal penalties

Basic Health may bill you for twice the amount due if you:

- Intentionally provide misleading or false income information.
- Withhold information about income.

If you intentionally provide false or misleading information or withhold information, Basic Health may take additional legal action, such as:

- Prosecution for perjury.
- Immediate disenrollment back to the date your coverage would have been affected. This means we will bill you for the total cost of your health coverage since that date.

In addition, if your health plan has paid for services during a time you were enrolled through fraud, it may demand you repay the health plan.

See Appendix B for information on HCTC.

Chapter Four: Suspension, Disenrollment, and Reenrollment

Suspension

If you (or your financial sponsor or employer, if enrolled through one) do not pay your premium on time, you will lose coverage for one month (suspension). If your premium is paid in full by the due date on your notice of suspension, you will be reenrolled the next month. If you lose coverage for one month, any payments you have made toward your deductible and out-of-pocket maximums will still count.

Disenrollment

To stop Basic Health or Basic Health Plus coverage for yourself, a family member, or your entire family, call 1-800-660-9840, or write to Basic Health, PO Box 42683, Olympia, WA 98504-2683. You must include:

- Your name and Basic Health ID number.
- The name of each person you want to disenroll.
- The reason you want to disenroll (especially if due to other insurance, Medicare, or Medicaid).
- The date you want coverage to end. We must receive your request to disenroll at least 10 days before the first of the month you want coverage to end.

You are no longer eligible for Basic Health and will be disenrolled if you:

- Leave Washington State with no plan to return, or if you are gone for more than three months in a row.
- Become eligible for free or purchased Medicare coverage, regardless of whether you actually have Medicare coverage.
- Become eligible for Medicaid or begin receiving medical assistance administered by the HCA. If you become eligible for other coverage, you will be transferred to that coverage.
- Enroll in Washington Health
- Have income above Basic Health's income guidelines.

If you are disenrolled because you became ineligible (as previously described) and your circumstances change, you may reapply for Basic Health coverage, but may have to wait until space is available.

You will be disenrolled from Basic Health and will not be allowed back in for at least 12 months if you:

- Are suspended for nonpayment three times in a 12-month period, or do not reenroll the month following a one-month suspension.
- Are billed for the amount Basic Health overpaid for your coverage, and you do not repay the amount based on the billing schedule we provide. (See "What if I don't report a change in income?" on page 10.)
- Do not provide documents Basic Health asks for to check your eligibility or income.
- Take part in any abuse, intentional misconduct, or fraud against Basic Health or your health plan or its providers, or knowingly give information to Basic Health that is false or misleading.
- Intentionally withhold required information, such as a change in income or family size.

See Appendix B for information on HCTC.

You may also be disenrolled from Basic Health if you:

- Purposely put the safety or property of Basic Health or your health plan, or its staff, providers, patients, or visitors, at risk.
- Refuse to follow procedures or treatment recommended by your provider and determined by your health plan's medical director to be essential to your health or the health of your child, and you have been told by your health plan that no other treatment is available.
- Repeatedly fail to pay copayments, coinsurance, or other cost-sharing requirements on time.
- Engage in intentional misconduct. This includes withholding from your health plan information you have about a legally responsible third party, or refusing to help your health plan collect from that legally responsible third party.

These conditions for loss of coverage also apply to family members enrolled on your Basic Health account.

Family members enrolled in Basic Health Plus or the Maternity Benefits Program may stay with these programs as long as they are eligible, even if your coverage is suspended for one month or you are disenrolled from Basic Health for failing to pay your required premium.

If your coverage ends, you will receive written notice of the reason, information about your right to appeal our decision, including how to request coninuing coverage while you appeal, and the date your coverage ends.

Disenrollment from employer, financial sponsor, or home care agency coverage

If you have Basic Health coverage through your employer, you may be able to continue your coverage through the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). Under COBRA, you can continue coverage for up to 18 months; however, you will have to pay the full cost of that coverage, including any premium share that had been paid by your employer. Contact your employer to find out if you qualify for COBRA coverage.

If you are no longer eligible for employer, home care agency, or financial sponsor coverage, but still qualify for individual Basic Health, Basic Health will offer you coverage on your own account. If you get an offer from us, you must tell us right away if you want to transfer to your own account. If you do, you must pay the premium for your continued coverage.

Reenrollment

The reenrollment process depends on the reason your Basic Health coverage ended and the amount of time since you last had coverage. When you reapply for Basic Health, you may be required to send in a new application, proof of income and residency, and proof of other continuous coverage.

Generally, when you disenroll from Basic Health, you must wait at least 12 months before you can reenroll, and may have to wait until space is available. However, the 12-month wait for reenrollment may be waived if:

- You left for other coverage, and you reapply for Basic Health within 30 days of losing other continuous coverage (you will be required to provide proof of other continuous coverage).
- You move out of the state, then move back to stay.
- You were disenrolled because you were no longer eligible for Basic Health coverage, but you are now eligible again.

Even if the 12-month wait for reenrollment is waived, if Basic Health is full, you will have to wait until space is available.

Reenrollment after disenrollment to Medicaid coverage

If you leave Basic Health for Medicaid coverage (for example Healthy Options, Health Options Blind Diables, or Medical Care Services), and then lose the Medicaid coverage, you may be eligible to reenroll in Basic Health without waiting for space to be available. You must request reenrollment in Basic Health within 30 days of losing Medicaid. When you re-apply to Basic Health you may be required to send a new application, proof of income, a copy of your IRS 1040 and all your schedules for the most current tax year, and proof of Washington State residency.

See Appendix B for information on HCTC.

Chapter Five:
Rights, Responsibilities, and Privacy

Basic Health member rights

As a Basic Health member, you have the right to:

- Get understandable notices or have the materials explained or interpreted.
- Receive timely information about your health plan.
- Get courteous, prompt answers from your health plan and Basic Health.
- Be treated with respect.
- Have your privacy protected by Basic Health, your health plan, and its providers.
- Get information about all medical services covered by Basic Health.
- Choose your health plan and primary care provider from among available health plans and their contracted networks. All covered family members must be enrolled in the same health plan.
- Receive proper medical care, consistent with Appendix A of this handbook, without discrimination no matter what your health status or condition, sex, ethnicity, race, marital status, or religion.
- Get all medically necessary covered services and supplies listed in the Basic Health Schedule of Benefits, subject to the limits, exclusions, and cost-sharing described in Appendix A.
- Take part in decisions about your and your child's health care, including having a candid discussion of appropriate or medically necessary treatment options, regardless of cost or coverage.
- Get medical care without a long delay.
- Refuse treatment and be told of the possible results of refusing, including if your refusal may result in disenrollment from Basic Health.
- Expect your and your child's records and conversations with providers to be kept confidential.
- Get a second opinion by another provider in your health plan when you disagree with the initial provider's recommended treatment plan.
- Make a complaint or grievance about the health plan or providers and receive a timely answer.
- File an appeal with your health plan or Basic Health if you are not satisfied with their decision (see pages 17-19).
- Receive a review of a Basic Health appeal decision, if you disagree with it.
- Change your primary care provider (call your health plan for assistance).

Informed consent

You have the right to give your consent to treatment or care. Be sure to ask your provider about the side effects of your or your child's care. You have the right to know about them, and give your consent before getting care.

Advance directives

Advance directives put your health care choices into writing. They may also name someone to speak for you if you are not able to speak. Before signing such a document, talk to a lawyer or legal counselor. Washington State law has two kinds of advance directives:

1. Durable Power of Attorney for Health Care – Names someone to make medical decisions for you if you are not able to make them for yourself.
2. A Directive to Physicians (Living Will) – A document that lets you tell your doctor what you do or do not want done if you have a terminal condition or are permanently unconscious.

Privacy

Personal health information

The Health Care Authority (HCA) will not release any personal health information that is provided verbally, electronically, or in writing to anyone but you or your health plan without your prior written authorization.

Account information

Without your written permission, the HCA cannot release personal account details such as eligibility, enrollment, monthly premium, or payment to anyone but you or your health plan.

Exceptions:

- If your employer, a home care agency, or a financial sponsor is paying your premium, limited information may be released to your representative. Ask your representative for details.
- Information about a dependent minor child will be released to either parent.
- Your information will be shared with Medicaid to determine eligibility for that coverage and continued eligibility for Basic Health. If you are found eligible for Medicaid, you will be transferred to that coverage.
- Providing information to law enforcement.

If you want to let someone else (such as a friend or a relative) access or make changes to your account, you must send written permission to Basic Health. Be sure to sign and date your letter and include the person's name, their relationship to you, and what information you want released to them or changes they can make. Only the information you specify will be released. You will also need to tell us if this permission is for a specific time period or for as long as you are enrolled in Basic Health. When this person calls, they'll need your Basic Health ID number, and will be asked for other identifying information.

The HCA privacy notice is available on request by calling 206-521-2035 or online at **www.hca.wa.gov**.

Basic Health member responsibilities

As a Basic Health member, you and/or your enrolled dependents have the responsibility to:

- Understand Basic Health.
- Accurately and promptly report changes that may affect your premium or eligibility, such as an address change, or a change in family status or income, and send in the required forms and documents. (Read chapters two and three for timelines and instructions.)
- Choose a single health plan in your area for all covered family memers.
- Choose a primary care provider from your health plan before receiving services.
- Work with your health plan to help get any third-party payments for medical care.
- Tell your health plan about any outside sources of health care coverage or payment, such as insurance coverage for an accident.
- Tell your or your child's primary care provider about medical problems, and ask questions about things you do not understand.
- Decide whether to receive a treatment, procedure, or service.
- Get medical services from (or coordinated by) your or your child's primary care provider, except in an emergency or in the case of a referral.
- Get a referral from the primary care provider before you or your child goes to a specialist.
- Pay copayments in full at the time of service.
- Pay your Basic Health premiums in full by the due date.
- Pay your deductible and coinsurance in full when they are due.
- Not engage in fraud or abuse in dealing with Basic Health, Basic Health Plus, the Maternity Benefits Program, your health plan, your primary care provider, or other providers.
- Keep appointments and be on time, or call the provider's office when you or your child will be late or can't keep the appointment.
- Keep your family members' medical ID cards with the family member at all times, or with you if your children are young.
- Notify the health plan or primary care provider within 24 hours, or as soon as is reasonably possible, of any emergency services provided outside the health plan.

- Use only your selected health plan and primary care provider to coordinate services for your family's medical needs.
- Comply with requests for information, including requests for medical records or information about other coverage, by the date requested.
- Cooperate with your primary care provider and referred providers by following recommended procedures or treatment.
- Work with your health plan and providers to learn how to stay healthy.

Chapter Six:
Grievances, Complaints, and Appeals

If you have a grievance or appeal about services from your health plan, its providers, or benefits, contact your health plan directly. You can find the toll-free numbers on the inside front cover of this book. If you disagree with the determination of your ineligibility for the Health Coverage Tax Credit, contact the HCTC Customer Contact Center for information. (See Appendix B for HCTC contact information.) If you have a complaint about an action taken by Basic Health, call 1-800-660-9840. If you call Basic Health or your health plan, be sure to note the date of the call, the name of the person you talked to, and whether that person was with Basic Health or your health plan.

Your health plan is required to give you information on its grievance and appeals process:

- When you enroll.
- Annually and/or whenever there is a change to their grievance and appeal process.
- When the health plan sends you a notice of a denial of a benefit or service, or notice of an appeal decision.

Grievances against your health plan

You have the right to file a grievance or appeal with your health plan if you are not happy with the way you have been treated or if you have been denied a medical service. The plan can help you file a grievance or an appeal.

Grievances or complaints can be about:

- A problem with your doctor's office,
- Getting a bill from your doctor, or
- Any other problems you may have getting health care.

Your health plan must let you know by phone or letter that they received your grievance or complaint within five working days. The plan must address your concerns within 30 days.

Things to know if a medical service is denied...there are time limits

A denial is when your health plan does not approve or pay for a service that either you or your doctor asked for. When your health plan denies a service, it will send you a letter about the denied service. The letter will let you know about your rights if you or your doctors do not agree with the plan's decision. After you get a denial letter, you have 90 days to ask for an appeal of the plan's decision. Within 5 working days, the plan will reply in writing telling you they received your request.

An appeal is when you ask the health plan to review your case because you disagree with their denial. With written consent, you can have someone appeal on your behalf. You only have 10 days to ask for an appeal if you want to keep getting a service that you are already getting while the plan reviews its decision. Your plan will review and decide your appeal within 14 days. Your plan must tell you if it needs more time (up to 30 days) to make a decision. The plan must get your written permission to take more than 30 days to make a decision. In any case an appeal decision must be made within 45 days.

NOTE: If you keep getting a service during the appeal process and you lose the appeal, you may have to pay for the services you received.

Is it urgent? For urgent medical conditions, you or your doctor can ask for an expedited (quick) review or hearing. If your medical condition requires it, a decision will be made about your care within 72 hours. To ask for an expedited appeal, tell your plan why you need the faster decision. If the health plan denies your request, your appeal will be reviewed in

the same time frames outlined above. Your plan must make reasonable efforts to give you prompt oral notice if it denies your request for an expedited appeal. Your plan must provide written notice within 2 calendar days of its decision.

If you disagree with the appeal decision from the plan, you have the right to ask Basic Health for a hearing within 90 days.

A hearing is when you ask Basic Health to review your case after your plan denied your appeal. DO NOT ask for a hearing from Basic Health before you get the plan's decision about your appeal.

To ask for a Basic Health Hearing:

- Call the Office of Administrative Hearings (www.oah.wa.gov) at 1-800-583-8271, or send a letter to P.O. Box 42489, Olympia, Washington, 98504-2489.
- Tell the Office of Administrative Hearings the reason for the hearing, what service was denied; the date it was denied; and the date that the appeal was denied. Also, be sure to give your name, address, and phone number.
- You may talk with a lawyer or have another person represent you at the hearing. If you need help finding a lawyer call the NW Justice CLEAR line at 888-201-1014, weekdays from 9:15 a.m. until 12:15 p.m., and Tuesdays from 3:30 p.m. until 6:15 p.m., or visit http://www.nwjustice.org/

After the hearing, the Office of Administrative Hearings will send you a letter with its decision. If you disagree with the hearing decision, you have the right to ask your plan for a review of your case by an Independent Review Organization (IRO). An IRO is a group of doctors, who do not work for your plan. You have 180 days to call your plan and ask for a review by an IRO after you get the OAH letter.

If you still do not agree with the decision of the IRO, you can ask to have the HCA Board of Appeals review your case. You only have 21 days to ask the HCA Board of Appeals to review the IRO's decision after getting your IRO decision letter. The HCA Board of Appeals decision is final. You can ask for an HCA Board of Appeals review by:

- Calling 1-877-351-0002 (TTD only: 360-664-6178), or
- Writing to the HCA Board of Appeals at P.O. Box 45803 Olympia, WA 98504-5803.

Complaints against Basic Health

If you have a complaint or want an explanation of an action Basic Health has taken on your account, write to Basic Health at PO Box 42683, Olympia, WA 98504-2683, or call 1-800-660-9840. A representative will try to resolve your issue.

Appeals to Basic Health related to your eligiblity or premiums

To appeal a decision of your health plan, please see "Grievances against your health plan" on page 17. To appeal a Basic Health decision related to your eligibility for the program, your monthlys premiums, or the loss of your coverage, follow the instruction in this section.

If you disagree with a Basic Health decision, such as premium calculation, denial of Basic Health eligibility, or loss of Basic health coverage you have the right to request a hearing within 90 days of the date on the notice telling you our decision. If you want your benefits to continue until a judge makes a decision, you must ask in writing for a hearing before the date of the action on the notice, and continue to pay all monthly premiums. If you do not know how to pay your premium call us at 1-800-660-9840.

- Mail your written hearing request to:
  Basic Health Appeals
  PO Box 42690
  Olympia, WA 98504-2690
- Tell us why you disagree with the action taken; what you want to change; and send any documents you have that support your request.
- You may wish to talk with a lawyer or have another person represent you at the hearing. If you need help finding a lawyer, check with the nearest Legal Services Office, or call the CLEAR hotline at 1-888-201-1014.
- Basic Health rules are found in Chapter 182-22 WAC. You can view state laws (RCW) and rules (WAC) online at http://www.leg.wa.gov/LawsAndAgencyRules/Pages/default.aspx. You can also view them at your public library reference desk or local law library. If you can't find this information, please call our office. You can ask for a copy of the rules. Please contact the HCA Office of Hearings and Appeals at1-800-351-6827 if you need assistance locating the rules.

If your benefits continue and the judge makes a decision that is not in your favor, you may be held financially responsible for services obtained under Basic Health.

Chapter Seven:
Health Plans and Providers

How the health plans work

All health plans offer the same basic benefits and require you to choose a primary care provider (PCP) to coordinate or provide your care. Costs, providers and facilities, covered prescription drugs, and referral practices, may differ by health plan.

Each health plan contracts with a number of providers and facilities (called the health plan's provider network). Your health plan may refer you to a specialist or facility outside the health plan's network if you or your child needs a provider or hospital not available inside your health plan's network. You must get your health plan's approval to be treated by a provider or facility not available through your health plan's provider network, except in an emergency (see page 22).

Some health plans may contract with provider groups called subnetworks; this may restrict your choice of providers. You may be required to see specialists or use facilities, such as hospitals, in the same subnetwork as your PCP. This means that even if a provider is in your health plan's provider network, the provider's services may not be available to you unless the provider is also in the same subnetwork as your PCP.

To make sure you're covered, call the health plan or your PCP to find out if your PCP can refer you to a provider with that health plan's provider network, or if your PCP can refer you to only a selected group of providers within the health plan.

When does my coverage begin?

Basic Health notifies you in writing when your coverage is effective. Take note of the effective date of coverage shown in that letter. Basic Health will not cover any services received before your coverage begins.

ID cards

After you enroll in Basic Health, your health plan will send you ID cards for you and your enrolled family members. Some health plans may require you to choose a PCP before they issue your ID card. The card has important information, including the number to call if you are hospitalized or have questions. If you need care before you receive the card, contact the health plan at the number listed on the inside front cover of this handbook. Remember to keep your enrollment confirmation letter from Basic Health; it can serve as your temporary identification until you receive your card(s).

The right to object to certain services

Religiously sponsored health plans, health care providers, or employers have the right to not provide benefits or services for termination of pregnancy or other services to which they object because of religious belief or issues of conscience. If your health plan or employer objects to providing a specific service that is normally provided, you will be told how to receive this particular service from another provider, with no added cost to you. Contact your health plan for more information.

If you object to having coverage for termination of pregnancy or other services, you may notify Basic Health in writing. Benefits will not be provided to you for those services; however, your premium will not change.

Primary care provider (PCP)

Each covered family member must enroll in the same health plan, but may choose a different PCP within your health plan. Except in an emergency, your PCP and staff will provide or coordinate all

your health care, including referrals to specialists. Primary care providers may be family or general practitioners, internists, pediatricians, or other providers approved by your health plan. You may change your PCP during the year. Contact your health plan for details on changing providers or for a current list of providers. You may also contact a provider you're considering to find out if the provider contracts with your health plan for Basic Health coverage. When you call a provider, be sure to mention the name of your health plan and Basic Health, and ask if the provider is accepting new patients.

To be covered by your health plan, your PCP must provide all health care services, unless:

- You are referred to another provider by your PCP (in most cases, the referral must be approved by your health plan);
- You need emergency care, as described on page 22; or
- You self-refer for women's health care services (see below) or covered chiropractic care to a provider who contracts with your health plan.

If you have questions, call your health plan at the number listed on the inside front cover of this handbook.

Women's health care services

The following women's health care services are covered by Basic Health without a PCP referral or health plan preauthorization:

- Maternity care, including prenatal, delivery, and postnatal care.
- Routine gynecological exams.
- Examination and treatment of disorders of the female reproductive system, except as specifically excluded in Appendix A of this handbook.
- Other health problems discovered and treated during the course of a woman's health care visit, as long as the treatment is within the provider's scope of practice, and the service provided is not excluded.

You may seek these services from any women's health care provider who contracts with your health plan. Services provided by hospitals or outpatient surgical centers may require preauthorization from your health plan. Also, any follow-up services for conditions not directly related to maternity care, routine gynecological exams, or disorders of the female reproductive system may require referral and preauthorization by your health plan.

Chapter Eight:
Covered Services and Member Costs

The list of services covered under Basic Health, called the "Schedule of Benefits," is in Appendix A of this handbook. If you have questions about a particular medical condition or Basic Health benefit, contact your health plan directly at the number listed on the inside front cover of this handbook.

Emergency care

Emergency care is covered 24-hours a day, seven days a week. (See page 40 for the definition of "emergency.") To receive emergency care benefits, it is important to follow these steps:

- Depending on how serious the problem is, go directly to the nearest emergency room, call 911, or call your PCP.
- If you are admitted to a hospital or other health care facility, call (or have a friend, family member, or staff member call) your health plan or PCP within 24 hours or as soon as is reasonably possible.
- See (or be referred by) your PCP for follow-up care.

Important: If you do not follow these instructions, and the provider bills for a higher amount than your health plan would pay a contracted provider, you may be required to pay the balance. If the case is determined not to be an emergency (whether or not you follow the instructions), you will be responsible for all costs.

Pre-existing condition waiting period

Basic Health enrollees are not subject to a pre-existing condition waiting period.

Maternity care

If you or an enrolled family member becomes pregnant, call 1-800-660-9840 right away. We will mail a Maternity Benefits Application for you to complete and return to us.

Basic Health only covers maternity services for 30 days after pregnancy is confirmed by a medical provider, unless you apply for the Maternity Benefits Program**.** This HCA program provides full maternity coverage and allows you to receive care through the same health plan you chose for your Basic Health coverage. When choosing a provider for your maternity care, make sure the PCP contracts with your chosen health plan to provide Maternity Benefits Program services through Basic Health.

The Maternity Benefits Program includes the following benefits at no **cost** during pregnancy and for two months after your pregnancy ends**:**

- Prenatal care
- Maternity support services
- Dental care
- Labor and delivery
- Family planning
- Physical therapy
- Postpartum care
- Transportation to appointments
- Childbirth education
- Maternity case management)

The HCA determines eligibility for the Maternity Benefits Program based on its eligibility criteria. Information about this program is available in a separate booklet called A Guide to Basic Health Plus and the Maternity Benefits Program. This document will be sent to you when you enroll in the Maternity Benefits Program.

Don't stop paying your Basic Health premiums until your effective date for your enrollment in the Maternity Benefits Program. Once you are enrolled in the Maternity Benefits Program, you will not have monthly premiums or copayments, and you will continue to receive your care from the health plan you chose through Basic Health. You still must pay the monthly premiums for any other family members enrolled in Basic Health.

If you do not meet citizenship requirements for the Maternity Benefits Program, you may be eligible for other HCA programs that cover maternity care. To receive these benefits, you must report your pregnancy to Basic Health.

If you do not apply for the Maternity Benefits Program, Basic Health will not cover the cost of any maternity services beyond 30 days after pregnancy is confirmed by a medical provider.

Maternity services will be covered by Basic Health if HCA finds you ineligible for maternity coverage. Refer to Appendix A for information on maternity coverage for those who are ineligible for the Maternity Benefits Program.

When your pregnancy ends

You must notify Basic Health at 1-800-660-9840 as soon as your pregnancy ends. We will mail you an application to add your newborn child to your Basic Health account. To avoid a break in coverage, Basic Health must receive your completed application to add your newborn within 60 days of the child's birth.

Your Basic Health medical coverage will resume when your maternity benefits end only if your family's Basic Health premiums (if any) have been paid while you were enrolled in the Maternity Benefits Program. For example, if you have a spouse and/or dependent(s) enrolled in Basic Health and they are disenrolled for nonpayment while you are covered through the Maternity Benefits Program, your coverage will continue until two months after your pregnancy ends. At that point, you will lose your coverage, and you and your family (except for children enrolled in Basic Health Plus) will not be able to reenroll in Basic Health for 12 months. In addition, if Basic Health is full at that time, you will have to wait until space is available.

If the pregnant family member is a child enrolled in Basic Health Plus, she does not need to apply for the Maternity Benefits Program, although you must notify Basic Health of the pregnancy. Her maternity benefits will be covered through Basic Health Plus. To continue the newborn's coverage, you or your daughter must notify Basic Health within 60 days of the end of her pregnancy by completing and returning the Family Changes Form or the Change Form included with your billing statement. To continue coverage for her newborn, your daughter may also need to enroll on her own account.

Member costs

Except for American Indian and Alaska Native enrollees as defined in Appendix B-1, each member in Basic Health is responsible for sharing in the cost of coverage as follows:

Copayment – A set dollar amount you pay when receiving specific services. In most cases, this will be $15, except for prescription drugs and emergency room visits.

Deductible – The amount you pay before your health plan starts to pay for covered services. You are responsible for paying the first $250 of certain covered medical costs before your health plan pays the 80% coinsurance. The $250 deductible must be met every calendar year for each family member enrolled in Basic Health. Your deductible does not apply towards your out-of-pocket maximum. You may receive a bill from your health plan and/or provider.

Coinsurance – For certain services, you will be responsible for paying 20% of the cost. Your health plan pays the remaining 80%. You may receive a bill from your health plan and/or provider.

Out-of-pocket maximum – Your coinsurance costs apply toward your out-of-pocket maximum of $1,500 per person, per calendar year. When you reach your out-of-pocket maximum, you do not have to pay any further coinsurance costs for covered benefits and services received during that year. Your health plan will pay 100% of the coinsurance for all covered benefits and services. The $1,500 out-of-pocket maximum applies to each family member enrolled in Basic Health.

If you change health plans any time during the year, the amount you've paid toward your deductible and out-of-pocket maximum for covered family members will start over with your new health plan.

See the "Schedule of Benefits" on page 25.

If you receive a bill for covered services

If you receive care from a provider who contracts with your health plan, the provider will usually bill the health plan directly.

You will receive a bill from a provider who has provided services to you that require a deductible and coinsurance. In most cases, your health plan will first send you an Explanation of Benefits (EOB) that will explain what service you received, what the allowed amount is for that service, what the health plan has paid, and what you have to pay. The EOB will also provide information about how much you have paid toward your deductible and out-of-pocket maximum. The provider or facility where you have received services will then send you a bill. You must pay the provider or facility directly. If you receive a bill but have not yet received an EOB, or if you have questions about your bill, contact the provider's office or your health plan.

In some cases, you may receive a bill from a provider or a facility that does not contract with your health plan, or from a provider who did not know about your Basic Health coverage. (When you fill out information for your provider, be sure to list the health plan that provides your coverage—not Basic Health.) If you receive a bill for services you think are covered by Basic Health but that have not yet been billed to your health plan, send the bill directly to your health plan at the address on your ID card. (Call your health plan at the number listed on the inside cover of this handbook for details.) Benefits may be denied if your health plan receives the bill more than 12 months after the date you received services.

If a third party is responsible for your injury or illness

You or your representative must notify your health plan if your provider charges the health plan for treatment of an injury or illness that is the result of another person's or organization's action or failure to act (for example, a fall, an auto accident, or an accident at work). The other person or organization responsible for your injury or illness is called the "third party."

You must, to the degree that you know, notify your health plan promptly, in writing, of all of the following:

- The facts of the injury or illness, including the name and address of any third party you think may be responsible for the injury or illness.
- The name and address of the third party's insurance company.
- The name and address of any attorneys who will be representing the third party.
- If you plan to file a claim or lawsuit against the third party, the name and address of the person who will be representing you.
- Adequate advance notice of any trial, hearing, or possible settlement of your claim against the third party.
- Any changes in your condition or injury.
- Any additional information reasonably requested by the health plan.

If you bring a claim or legal action against a liable third party, you must seek recovery of the benefits paid by your health plan.

After you have been fully compensated for all damages you experienced as a result of the accident, your health plan has a right to reimbursement up to the amount of the benefits the health plan has paid, from any recovery you receive. You are required to pay the health plan only the amount that is left over after you have been fully compensated for all of your damages (including pain and suffering and lost wages), up to the amount of the benefits paid.

If your health plan seeks to recover benefits directly from the third party, you must cooperate fully and not do anything to impair your health plan's right of recovery. Your health plan may bring suit against the third party in your name, or may join as a party in a lawsuit or claim you have filed. Your health plan will not be required to pay for legal costs you incur, and you will not be required to pay legal costs incurred by your health plan. However, your health plan may agree to share the cost if they choose to be represented by your attorney.

Basic Health can disenroll you for intentional misconduct if you:

- Withhold from your health plan information you have about a legally responsible third party.
- Refuse to help your health plan collect from that legally responsible third party.

Appendix A:
Schedule of Benefits

This "Schedule of Benefits" lists benefits for Basic Health members. Services are subject to all provisions of this "Schedule of Benefits," including limitations, exclusions, deductibles, coinsurance, and copayments. Except as specifically stated otherwise, all services and benefits under Basic Health must be provided, ordered, or authorized by the health plan or its contracting providers. Even if your provider authorizes a service, your health plan may also need to preauthorize the care.

Services in addition to those listed in this "Schedule of Benefits" may be provided at the sole discretion of the health plan through the health plan's medical management or case management program if providing the service will result in a lower total out-of-pocket cost to the health plan. Additional services may be subject to copayments, deductibles, coinsurance, and limitations.

If you have a question about the benefits listed, or are not sure if a service is covered, you should call the health plan's customer service department.

I. Medically necessary services, supplies, or interventions

Basic Health provides coverage for services, supplies, or interventions that are otherwise included as a "covered service," as set forth in Section II, that are not excluded and are medically necessary. A covered service is "medically necessary" if it is recommended by your treating provider and your health plan's medical director or provider designee, and if all of the following conditions are met:

A. The purpose of the service, supply, or intervention is to treat a medical condition.

B. It is the most appropriate level of service, supply, or intervention considering the potential benefits and harm to the patient.

C. The level of service, supply, or intervention is known to be effective in improving health outcomes.

D. The level of service, supply, or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention.

E. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion.

A health "intervention" is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat, or palliate) a medical condition (i.e., disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation), or to maintain or restore functional ability. For purposes of this definition of "medical necessity," a health intervention means not only the intervention itself, but also the medical condition and patient indications for which it is being applied.

"Effective" means that the intervention, supply, or level of service can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

An intervention, supply, or level of service may be medically indicated yet not be a covered benefit or meet the standards of this definition of "medical necessity." Your health plan may choose to cover interventions, supplies, or services that do not meet this definition of "medical necessity;" however, the health plan is not required to do so.

"Treating provider" means a health care provider who has personally evaluated the patient.

"Health outcomes" are results that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

An intervention is considered to be new if it is not yet in widespread use for the medical condition and patient indications being considered.

"New interventions" for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion (see "existing interventions" below).

"Scientific evidence" consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

For "existing interventions," the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of "medical necessity." If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the Basic Health definition of "medical necessity" in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

A level of service, supply, or intervention is considered "cost effective" if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative. Cost-effective does not necessarily mean lowest price.

II. Covered services

The following services are covered when they are medically necessary. All services, supplies, and interventions are subject to the appropriate copayment, deductible, and coinsurance. (See Section III. Copayments, deductibles, and coinsurance.)

A. Hospital care

The following hospital services are covered:

1. Semi-private room and board, including meals; private room and special diets; and general nursing services.
2. Hospital services, including use of operating room and related facilities, intensive care unit and services, labor and delivery room when eligible for Basic Health maternity benefits, anesthesia, radiology, laboratory, and other diagnostic services.
3. Normal newborn baby care following birth while in a contracting facility when not eligible for coverage under the "Maternity care" benefit. Covered services include, but are not limited to, nursery and laboratory services.
4. Drugs and medications administered while an inpatient.
5. Special duty nursing.
6. Dressings, casts, equipment, oxygen services, and radiation and inhalation therapy.

If a member is hospitalized in a non-contracting facility, the health plan has the right to require transfer of the member to a contracting health plan facility at the health plan's expense, when the member's condition is sufficiently stable to enable safe transfer.

If the member refuses to transfer to a contracting facility, all further costs incurred during the hospitalization are the responsibility of the member.

Personal comfort items such as telephone, guest trays, and television are not covered.

B. Medical and surgical care

The following medical and surgical services are covered. The health plan may require that certain medical and surgical services be provided on an outpatient basis.

1. Surgical services.
2. Radiology, nuclear medicine, ultrasound, laboratory, and other diagnostic services.
3. Dressings, casts, and use of cast room; anesthesia and anesthesia-related oxygen services.
4. Blood, blood components, and fractions (such as plasma, platelets, packed cells, and albumin), and their administration.
5. Provider visits, including diagnosis and treatment in the hospital, outpatient facility, or office; consultations, treatment, and second opinions by the member's PCP, or by a referral provider. Normal newborn baby care following birth while in a contracting facility when not eligible for coverage under the "Maternity care" benefit. Covered services include, but are not limited to, routine newborn exams and laboratory services.

   Pharmaceuticals that are or would normally be an intrinsic part of a provider visit (inpatient or outpatient) are covered as part of the provider visit.
6. Radiation therapy; chemotherapy.
7. Inpatient and outpatient chiropractic, occupational, and physical therapy services are covered for only post-operative treatment of reconstructive joint surgery when received within one year following surgery. A combined maximum of 12 visits per calendar year are covered, but no more than six visits can be covered for chiropractic care. Diagnostic or other imaging procedures solely for determination of therapy services are not covered. Covered chiropractic services may be referred or self-referred to contracted providers.
8. Prescription drugs and medications as defined in "Pharmacy benefit."
9. Family planning services provided by the member's PCP or women's health care provider. Contraceptive supplies and devices (such as, but not limited to, IUDs, diaphragms, cervical caps, and long-acting progestational agents) determined most appropriate by the PCP or women's health care provider for use by the member are also covered. Over-the-counter supplies such as condoms and spermicides are covered only when part of a health plan protocol at the health plan's discretion. Elective sterilization is covered.

C. Maternity care

For pregnant Basic Health members who are determined to be eligible for medical assistance through the Health Care Authority (HCA), Basic Health only covers maternity care services for a period not to exceed 30 days following diagnosis of pregnancy.

The following maternity care services are covered for members who are determined to be ineligible for medical assistance through HCA. These services are not subject to copays, coinsurance, or deductibles: diagnosis of pregnancy; full prenatal care after pregnancy is confirmed; delivery; postpartum care; care for complications of pregnancy; preventive care; physician services; hospital services; operating or other special procedure rooms; radiology and laboratory services; medications; anesthesia; normal newborn care following birth, such as, but not limited to, nursery services and pediatric exams; and termination of pregnancy (including voluntary termination of pregnancy).

D. Chemical dependency

Members are eligible to receive residential and outpatient chemical dependency treatment from a health plan-contracting approved treatment program to a maximum benefit of $5,000 in a 24 consecutive calendar month period up to a lifetime benefit maximum of $10,000. Covered residential and outpatient treatment includes services such as diagnostic evaluation and education, and organized individual and group counseling. The hospital inpatient deductible and coinsurance applies to intensive inpatient services. Health plans may use lower copayments, if applicable, for group sessions.

(**NOTE:** Court-ordered treatment will be covered only if determined by the health plan to meet the Basic Health definition of "Medical Necessity." See page 25.)

In determining the $5,000 limit, the health plan reserves the right to take credit for chemical dependency benefits paid by any other group medical plan on behalf of a member during the immediate preceding 24 consecutive calendar month period. In determining the $10,000 lifetime limit, the health plan reserves the right to take credit for chemical dependency benefits paid under Basic Health on behalf of the member from January 1, 1988.

E. Mental health services

Mental health services are covered as follows:

Inpatient care in a participating hospital or other appropriate licensed facility approved by the health plan is covered in full (subject to deductible and coinsurance).

Outpatient care, including individual and family counseling, is covered subject to a $15 copayment per visit for individual sessions. Health plans may use lower copayments, if applicable, for group sessions. Visits for the sole purpose of medication management are covered as other provider visits.

(NOTE: Court-ordered treatment will be covered only if determined by the health plan to meet the Basic Health definition of "Medical Necessity." See page 25.)

F. Organ transplants

Services related to organ transplants, including professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery, and follow-up care, are covered. Deductible, coinsurance, and copayments apply by specific service. (See Section III. Copayments, deductibles, and coinsurance.) This benefit includes covered donor expenses.

Heart, heart-lung, liver, bone marrow including peripheral stem cell rescue, cornea, kidney, and kidney-pancreas human organ transplants are covered when the Basic Health definition of "Medical Necessity" is met. See page 25.

Organ transplant recipient: All services and supplies related to the organ transplant for the member receiving the organ, including transportation to and from a health plan-designated facility (beyond that distance the member would normally be required to travel for most hospital services), are covered in accordance with the transplant benefit language, provided the member has been accepted into the treating facility's transplant program and continues to follow that program's prescribed protocol.

Organ transplant donor: The donor's initial medical expenses relating to harvesting of the organ(s), as well as the costs of treating complications directly resulting from the procedure(s), are covered, provided the organ recipient is a member of the health plan, and provided the donor is not eligible for such coverage under any other health care plan or government-funded program.

Basic Health enrollees are not subject to a pre-existing condition waiting period.

G. Emergency care

An emergency is a sudden or severe health problem that needs treatment right away; there is not time to talk to your doctor.

"Emergency" is defined as:

> "The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy."

The health plan reserves the right to determine whether the symptoms indicate a medical emergency. Acute detoxification is covered for up to 72 hours.

1. In-service-area emergency. In the event a member experiences a medical emergency, care should be obtained from a health plan-contracting provider. If, as a result of such emergency, the member is not able to use a health plan-contracting provider, the member may obtain emergency services from non-contracting health care providers. Follow-up care must be provided or approved by the health plan in advance. In the case of emergency hospitalization, the member, or person assuming responsibility for the member, must notify the health plan within 24 hours of admission, or as soon thereafter as is reasonably possible. If the member fails to meet the notification requirements, coverage will be limited to what would have been payable by the health plan to a health plan-contracting provider had notification requirements been met. The member will be financially responsible for any remaining balance.
2. Out-of-service-area emergency. The health plan shall bear the cost of out-of-service-area emergency care for covered conditions. In the event of emergency hospitalization, the member, or person assuming responsibility for the member, must notify the health plan within 24 hours of admission, or as soon thereafter as is reasonably possible. If the member fails to meet the notification requirements, coverage will be limited to what would have been payable by the health plan to a health plan-contracting provider, had notification requirements been met. The member will be financially responsible for any remaining balance.

   The health plan may, at its discretion, appoint a consultant when out-of-service-area care is necessary, who will have authority to monitor the care rendered and make recommendations regarding the treatment plan. The health plan may otherwise secure information which it deems necessary concerning the medical care and hospitalization provided to the member for which payment is requested.
3. Transfer and follow-up care. If a member is hospitalized in a non-contracting facility, the health plan reserves the right to require transfer of the member to a health plan-contracting facility, when the member's condition is sufficiently stable to enable safe transfer. If the member refuses to transfer to a contracting facility, all further costs incurred during the hospitalization are the responsibility of the member.

   Follow-up care that is a direct result of the emergency must be obtained from a health plan-contracting provider, unless a health plan-contracting provider has authorized the member to continue to receive follow-up care from another provider in advance.
4. Prescription drugs. Prescription drugs purchased from a non-contracting facility or pharmacy are covered subject to the applicable pharmacy copayment when dispensed or prescribed in connection with covered emergency treatment.
5. Emergency ambulance transportation. Medically necessary ambulance transportation is covered in an emergency, or to transfer a member when preauthorized by the health plan.

H. Skilled nursing and home health care benefits

As an alternative to hospitalization in an acute care facility, the health plan, at its discretion, may authorize benefits for the services of a skilled nursing facility or home health care agency.

I. Hospice services

Hospice services are covered.

J. Plastic and reconstructive services

Plastic and reconstructive services (including implants) will be provided only under the following conditions:

1. To correct a physical functional disorder resulting from a congenital disease or anomaly;
2. To correct a physical functional disorder following an injury or incidental to covered surgery; and
3. For a member who is receiving benefits in connection with a mastectomy:
   a. Reconstruction of the breast on which the mastectomy was performed;
   b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
   c. Prostheses (internal and external) and physical complications of all stages of mastectomy.

   Treatment of lymphedemas is covered; however, durable medical equipment and supplies used to treat lymphedemas may be covered only in limited circumstances. Please contact your health plan for specific coverage information.

K. Preventive care

Preventive care services are covered, and will be provided as described in the schedule provided to you by the health plan.

L. Pharmacy benefit

The health plan may limit the drugs covered through use of a list called a "formulary." Each health plan's formulary includes all major therapeutic classes of drugs. Drugs not in the formulary will be covered if the health plan's medical staff determines that no formulary drugs are an acceptable medication for the patient.

In addition to the formulary just described, each health plan will have the following five therapeutic classes of drugs covered under the first tier, subject to a $10 copay; inhaled short-acting beta-agonists, inhaled steroids, inhaled anticholinergic bronchodilators, beta-blockers for severe heart failure, and anti-platelet clotting inhibitors for patients after intra-arterial stent placement. The member's copay will be $10 regardless (or independent) of the drug's generic or name brand status.

If you have a question about the pharmacy benefit, are not sure if a drug is covered, or believe a nonformulary drug should be covered, call the health plan's customer service department.

Basic Health covers drugs of all types, including prescribed creams, ointments, and injections, at the copayment levels shown. Prescriptions are not subject to the deductible and will not apply towards the annual out-of-pocket maximum.

When the actual cost of the drug is less than the $10 copay, members are only responsible for the cost of the drug.

Prescriptions are limited to a 30-day supply.

Drugs for cosmetic purposes are excluded unless preauthorized.

(See table below for more pharmacy copayment information.)

Tier 1 – Copayment: $10	Tier 2– Copayment: 50%
Covered drugs:	**Covered drugs:**
Generic drugs contained in the health plan's formulary. All oral contraceptives in the health plan's formulary. Diabetic supplies, including syringes and needles, diabetic test strips, lancets, and insulin. Inhaled short-acting beta-agonists. Inhaled steroids. Inhaled anticholinergic bronchodilators. Beta-blockers for severe heart failure. Anti-platelet clotting inhibitors for patients after intra-arterial stent placement.	Brand-name drugs in the health plan's formulary.

M. Oxygen

Oxygen will be covered when prescribed by a contracted provider and when authorized by a contracted health plan. The health plan, at its discretion, may require an assessment to determine if oxygen therapy is still an appropriate treatment before authorizing continued oxygen treatment.

Coverage for oxygen will include the rental of oxygen equipment, oxygen contents, and supplies for the delivery of oxygen.

Portable oxygen is not covered when provided only as a backup to a stationary oxygen system.

Oxygen is not subject to a copay or coinsurance, and is excluded from the Durable Medical Equipment exclusion.

III. Copayments, deductibles, and coinsurance

Each member is responsible for paying a $250 deductible per calendar year before some benefits and services will be covered (see page 33). For those services with a coinsurance, once the deductible has been met, the health plan pays 80% of allowed charges and the member pays 20% of allowed charges. All coinsurance payments will be applied toward the annual out-of-pocket maximum. For each member, the out-of-pocket maximum is $1,500 per calendar year. No amount paid toward the $250 deductible will be applied toward the out-of-pocket maximum. Once the out-of-pocket maximum has been reached, the health plan pays 100% towards all covered benefits and services with a coinsurance.

The member is responsible for paying any required copayment, deductible, and/or coinsurance directly to the provider of a covered service unless instructed by the health plan to make payment to another party. Copayments, deductibles, and coinsurance payments must be paid in full, or service may be denied or rescheduled.

Only the cost sharing specifically listed in the following tables will be charged to members for covered services. Members may be charged a missed appointment fee by a provider if they repeatedly fail to keep appointments, or to give timely notice when it is necessary to cancel appointments.

Benefits and services NOT subject to the deductible and coinsurance

The $250 annual deductible and $1,500 out-of-pocket maximum per person, per calendar year DO NOT apply to the following benefits and services.

Benefit/service	Member's payment responsibility	Notes
Preventive care	No copay	Includes routine physicals, immunizations, PAP tests, mammograms, and other screening and testing when provided as part of the preventive care visit.
Office visits	$15 copay	Copay is for office visit only and includes consultations, mental health and chemical dependency outpatient visits, office-based surgeries, and follow-up visits. Copays do not apply to preventive care, laboratory, radiology services, radiation, and chemotherapy. Some services will be subject to coinsurance.
Pharmacy*		30-day supply
Tier 1	$10 copay (or cost of drug, whichever is less.)	Tier 1 includes generic drugs in health plan's preferred drug list (formulary).
Tier 2	50% of the drug cost	Tier 2 includes brand-name drugs in health plan's preferred drug list (formulary).
Emergency room visit	$100 copay	No copay if admitted; hospital coinsurance and deductible would apply.
Out-of-area emergency services	$100 copay	No copay if admitted; hospital coinsurance and deductible would apply.
Urgent care	$15 copay	Copay is for office visit only, when provided in an urgent care setting. Deductible and coinsurance apply to all other services.
Skilled nursing, hospice, and home care	No copay	Covered as an alternative to hospital care at the health plan's discretion.
Maternity care	No copay	If the member is eligible for the Maternity Benefits Program, maternity services can only be covered under Basic Health for 30 days following diagnosis of pregnancy. All other maternity services are covered through the Maternity Benefits Program administered by the Health Care Authority.
Oxygen	No copay	Includes equipment and supplies. Not subject to copays, coinsurance, or deductible. Requires health plan authorization.

* Different health plans have different lists of approved prescription drugs (formularies). To find out if a specific drug is covered in your pharmacy benefit, contact your health plan.

Benefits and services subject to the deductible and coinsurance

Before your health plan pays the 80% coinsurance for the following benefits, you must pay your $250 annual deductible. Once you meet your deductible, all coinsurance payments will be applied toward your $1,500 annual out-of-pocket maximum. Deductibles and out-of-pocket maximums are per person, per year. Once the $1,500 per person out-of-pocket maximum has been reached, the health plan pays for all covered benefits and services with a coinsurance. Members are only responsible for copays for benefits and services as shown on page 32. If you change health plans any time during the year, the amount you've paid toward your deductible and out-of-pocket maximum for covered family members will start over with your new health plan.

Benefit/service	Member's payment responsibility	Notes
Hospital, inpatient	20% coinsurance; deductible applies. $300 maximum facility charge per admittance.	Facility charges may include, but are not limited to, room and board, prescription drugs provided while an inpatient, and other services received as an inpatient. No charges for maternity care or when readmitted for the same condition within 90 days. If the member is eligible for the Maternity Benefits Program, maternity services can only be covered under Basic Health for 30 days following diagnosis of pregnancy. All other maternity services are covered through the Maternity Benefits Program administered by the Health Care Authority. See "Other professional services" below.
Hospital, outpatient	20% coinsurance; deductible applies.	
Other professional services	20% coinsurance; deductible applies.	Includes services received as an inpatient including, but not limited to, surgeries, anesthesia, chemotherapy, radiation, and other types of inpatient and outpatient services.
Mental health	20% coinsurance; deductible applies to inpatient. $300 maximum facility charge per admittance.	Facility charges may include, but are not limited to, room and board, prescription drugs provided while an inpatient, and other services received as an inpatient. Outpatient visits are subject to $15 copay (see "Office visits" on page 32).
Laboratory	No copay or coinsurance for outpatient services. 20% coinsurance for inpatient hospital-based laboratory services.	Deductible applies to services with coinsurance.
Radiology	20% coinsurance, except for outpatient x-ray and ultrasound.	Deductible applies to services with coinsurance.
Ambulance services	20% coinsurance; deductible applies.	Includes approved transfers from one facility to another. No coinsurance if transfer is required by the health plan.
Chiropractic/physical therapy/occupational therapy	20% coinsurance; deductible applies.	Up to a combined maximum of 12 visits per year. (Of those, no more than six can be for chiropractic care.) Visits qualify only when used as post-operative treatment following reconstructive joint surgery. Visits must be within one year of surgery.
Chemical dependency	20% coinsurance and deductible apply. $300 maximum facility charge per admittance.	Limited to $5,000 every 24-month period; $10,000 lifetime maximum. Outpatient visits are subject to $15 copay (see "Office visits" on page 32).
Organ transplants	Deductible, coinsurance, and copays apply by specific service.	Transplants that are not preauthorized or are not performed in a health plan-designated medical facility are not covered. No benefits are provided for charges related to locating a donor, such as tissue typing of family members.

IV. Limitations and exclusions

A. Limitations

1. Pre-existing condition waiting period

   Basic Health enrollees are not subject to a pre-existing condition waiting period.

2. Major Disaster or Epidemic

   If the health plan is prevented from performing any of its obligations hereunder in whole or part as a result of a major epidemic, act of God, war, civil disturbance, court order, labor dispute, or any other cause beyond its control, the health plan shall make a good faith effort to perform such obligations through its then-existing and contracting providers and personnel. Upon the occurrence of any such event, if the health plan is unable to fulfill its obligations either directly or through contracting providers, it shall arrange for the provision of alternate and comparable performance.

3. Coordination of Benefits

   The benefits available under Basic Health shall be secondary to the benefits payable under the terms of any health plan that provides benefits for a Basic Health member except where in conflict with Washington State or federal law.

B. Exclusions

The services listed below are not covered:

1. Services that do not meet the Basic Health definition of "Medical Necessity" for the diagnosis, treatment, or prevention of injury or illness, or to improve the functioning of a malformed body member, even though such services are not specifically listed as exclusions.
2. Services not provided, ordered, or authorized by the member's health plan or its contracting providers, except in an emergency.
3. Services received before the member's effective date of coverage.
4. Custodial or domiciliary care, or rest cures for which facilities of an acute care general hospital are not medically required. Custodial care is care that does not require the regular services of trained medical or allied health care professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered.
5. Hospital charges for personal comfort items; or a private room unless authorized by the member's health plan; or services such as telephones, televisions, and guest trays.
6. Emergency facility services for nonemergency conditions.
7. Charges for missed appointments or for failure to provide timely notice for cancellation of appointments; charges for completing or copying forms or records.
8. Sleep studies, except the initial sleep study authorized by the contracted health plan. Only one sleep study per member per calendar year is covered.
9. Transportation except as specified under "Organ transplants" and "Emergency care."
10. Immunizations, except as covered under preventive care. Immunizations for the purpose of travel, employment, or required because of where you reside are not covered.
11. Implants, except: cardiac devices, artificial joints, intraocular lenses (limited to the first intraocular lens following cataract surgery), and implants as defined in the "Plastic and reconstructive services" benefit.
12. Sex change operations.

13. Investigation of or treatment for infertility or impotence.
14. Reversal of sterilization.
15. Artificial insemination.
16. In-vitro fertilization.
17. Eyeglasses, contact lenses (except the first intraocular lens following cataract surgery); routine eye examinations, including eye refraction, except when provided as part of a routine examination under "Preventive care."
18. Hearing aids.
19. Orthopedic shoes and routine foot care.
20. Speech and recreation therapy.
21. Medical equipment and supplies not specifically listed in this "Schedule of Benefits" except while the member is hospitalized (including, but not limited to, hospital beds, wheelchairs, and walk aids).
22. Dental services, including orthodontic appliances, and services for temporomandibular joint problems, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that such repair begins within ninety (90) days of the accidental injury or as soon thereafter as is medically feasible, provided the member is eligible for covered services at the time that services are provided.
23. Medical services, drugs, supplies, or surgery directly related to the treatment of obesity, including morbid obesity (such as, but not limited to, gastroplasty, gastric stapling, or intestinal bypass).
24. Weight loss programs.
25. Cosmetic surgery, including treatment for complications of cosmetic surgery, except as otherwise provided in this "Schedule of Benefits."
26. Medical services received from or paid for by the Veterans Administration or by state or local government, except where in conflict with Washington State or federal law or regulation; or the portion of expenses for medical services payable under the terms of any insurance policy that provides payment toward the member's medical expenses without a determination of liability to the extent that payment would result in double recovery.
27. Conditions resulting from acts of war (declared or not).
28. Direct complications arising from excluded services.
29. Replacement of lost or stolen medications.
30. Evaluation and treatment of learning disabilities, including dyslexia.
31. Any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracting provider, and authorized in advance by the health plan.

C. Changes to covered services and premiums

Basic Health may from time to time revise this "Schedule of Benefits." In designing and revising this "Schedule of Benefits," Basic Health will consider the effects of particular benefits, copayments, deductibles, coinsurance, out-of-pocket maximums, limitations, and exclusions on access to medically necessary basic health care services, as well as the cost to members and to the state. Generally accepted practices of the health insurance and managed health care industries will also be taken into account.

Basic Health will provide you with written notice of any planned revisions to your Basic Health premiums or the benefit plan at least 30 days prior to the effective date of the change. This notice may be included with your premium statement, open enrollment materials or other mailing, or may be a separate notice. For purposes of this provision, notice shall be deemed complete upon depositing the written revisions in the United States mail, first-class postage paid, directed to you at the mailing address you provided to Basic Health.

Appendix B: Health Coverage Tax Credit (HCTC) – Basic Health

Program overview

The Health Coverage Tax Credit (HCTC) is a federal income tax credit that pays 72.5 percent of the health plan premium for eligible people enrolled in "qualified health plans." In Washington State, Basic Health is a qualified health plan. However, in Basic Health materials, "health plan" refers to the company that provides your health care coverage (see page ii). For information on other qualified plans in Washington, call the HCTC Customer Contact Center or visit the Internal Revenue Service (IRS) website (see "HCTC contact information" on page ii).

Eligibility

To be eligible for the HCTC, you do not need to be eligible for Basic Health. You may be eligible if you are a displaced worker, enroll in a qualified health plan (such as Basic Health), and:

- Receive Trade Readjustment Allowance (TRA) under the Trade Adjustment Assistance (TAA) Act or Alternative Trade Adjustment Assistance (ATAA);
- Would be eligible to receive TRA but have not yet used all of your unemployment insurance benefits; or
- Are age 55 or over, receive pension benefits from the Pension Benefits Guaranty Corporation, and are not entitled to Medicare Part A.

To find out if you are eligible or to register for the tax credit, contact the HCTC Customer Contact Center or visit the HCTC website (see "HCTC contact information" on page ii).

Premiums

If you are eligible for the HCTC, you may claim it as an advance credit to help pay your premiums, or you may claim it when you file your federal income tax return. Either way, the tax credit will pay 72.5 percent of your HCTC-Basic Health premium. You pay the other 27.5 percent.

HCTC-Basic Health members are billed the full cost of their coverage, plus an administrative fee. Premiums are adjusted according to age, choice of health plan, and the county where services are provided. If you are claiming the HCTC advance tax credit for your Basic Health enrollment, you will receive a monthly invoice from the IRS. You will pay the IRS your share of the premium each month, and the IRS will pay Basic Health for your coverage. If you do not pay your share of the premium to the IRS on time, the IRS will not pay your premium and you will lose coverage for one month. You may be able to continue your coverage by paying the full premium directly to Basic Health for up to two months or applying for subsidized Basic Health coverage. Basic Health cannot accept your direct payment prior to enrolling in HCTC-Basic Health.

Making changes

HCTC-Basic Health members must report family changes, address changes, and changes in their HCTC eligibility to Basic Health. If you ask to have members added or removed from your account, Basic Health will send you a premium change notice; you must forward that notice to the IRS. To tell us about a change to your account, call 1-800-660-9840, fax a letter to 360-725-2047, or send a letter to HCTC-Basic Health at PO Box 42703, Olympia, WA 98504-2703. Be sure to include your HCTC-Basic Health ID number on all

correspondence.

If you move and your current health plan is not available in your new area, you will be required to choose a health plan that serves your new area. Otherwise, you may change health plans only during open enrollment, or when you move and your current health plan will cost more or a health plan is available that was not previously available. An exception may be made in some cases if you can prove that you need to continue a current course of treatment with a specific provider. When you change health plans, remember that each health plan contracts with different providers and has its own list of covered prescription drugs. Call the health plan or your provider to find out if your provider contracts with the health plan you are considering. If you take any prescription medications, you also should contact the health plan to see if your medications will be covered.

If you live outside Washington State, you will be asked to choose a county within Washington where you will receive your medical services. You must choose a health plan within that county. If you move, please call Basic Health at 1-800-660-9840 to discuss whether you will remain with the same health plan and in the same county of service. If you are covering a child who is away from home attending college, that child must also get HCTC-Basic Health services through the health plan and in the Washington State county you have chosen. Only emergency services are covered outside of the health plan's service area.

If you change health plans, any services you had approved under your previous health plan will need to be reviewed and approved again by your new health plan. Also, your deductible and out-of-pocket maximum will start over with the new health plan. Check with your health plan for further information.

Basic Health is committed to making sure your health plan is available throughout the year. However, if your health plan becomes unavailable during the year, you will be able to choose from among the other plans in your county. If only one health plan remains, you will be assigned to that plan.

If you want to add or remove a family member from your HCTC-Basic Health account, please call Basic Health. We will send you an updated monthly premium notice that you can forward to the HCTC program. Please note that we will need a signature from anyone age 18 or over who is added to your account. It is important that you contact us before you want a change to be effective. Because premiums for your HCTC-Basic Health coverage are paid for by the IRS, and HCTC-Basic Health cannot cover a family member until the premium is received from the IRS, you should allow plenty of time.

Suspension, disenrollment, and reenrollment

If Basic Health does not receive your premium from the IRS by the first of the month, you will not have coverage for that month. (Any payments you have made toward your deductible and out-of-pocket maximums will remain intact.) In this case, you may pay the full cost of your own coverage. However, because nonpayment from the IRS can mean you are no longer eligible for the program, you will only be able to pay your own premium for two months before you will be disenrolled from HCTC-Basic Health. If you have not already been notified by the IRS of the reason for not paying your HCTC-Basic Health premium, call the HCTC Customer Care Center at 1-866-628-4282.

You may also be disenrolled from HCTC-Basic Health if you:

- Take part in any form of abuse, intentional misconduct, or fraud against Basic Health or your health plan or its providers, or knowingly give information to Basic Health that is false or misleading;
- Intentionally withhold information required by HCTC or Basic Health;
- Pose a risk to the safety or property of Basic Health or your health plan, or their staff, providers, patients, or visitors;
- Refuse to follow procedures or treatment recommended by your provider and determined by your health plan's medical director to be essential to your health or the health of your child, and you have been told by your health plan that no other treatment is available;
- Repeatedly do not pay copayments, coinsurance, or other payments on time; or
- Withhold from your health plan information you have about a legally responsible third party, or refuse to help your health plan collect from that legally responsible third party.

If you want to disenroll from HCTC-Basic Health, contact Basic Health. However, if you plan to change your HCTC coverage

to another qualified health plan, you should contact the HCTC Customer Contact Center first.

Rights, responsibilities, and privacy

All information in Chapter Five (Rights, Responsibilities, and Privacy) applies to HCTC-Basic Health members, except as noted below.

- As an HCTC-Basic Health member, you have the right to file an appeal with your health plan or with the federal HCTC program if you are not satisfied with their decision. You will not have an appeals process with Basic Health unless you have paid 100 percent of your premium for the time in question.
- As an HCTC-Basic Health member, you do not have to provide Basic Health with information about your income.
- As an HCTC-Basic Health member, you are not required to pay your premium directly to Basic Health, unless notified. The IRS will send your monthly premium to Basic Health. You will pay 20 percent of that amount directly to the HCTC program.

HCTC-Basic Health grievances and appeals

If you have a grievance or appeal about services from your health plan, its providers, or benefits, contact your health plan directly. You can find the toll-free numbers on the inside front cover of this handbook. For more information on grievences with your health plan, read "Grievances against your health plan" on page 17.

If you disagree with a decision that you are not eligible for the HCTC program, contact the HCTC Customer Contact Center.

If you have paid 100 percent of your Basic Health premium, and have a complaint about something Basic Health did during the time you paid your own premium, go to page 17.

Whenever you call any of these organizations, be sure you note the date of the call, the name of the person you talked to, and whether that person was with the HCTC program, your health plan, or Basic Health.

Health plans and providers

All of Chapter Seven applies to HCTC-Basic Health members.

Covered services

Benefits for HCTC-Basic Health members are the same as for all Basic Health members (see page 26), with the following exception:

- HCTC-Basic Health covers maternity benefits without requiring that you apply for the Maternity Benefits Program. Covered maternity services are listed on page 27.

Member costs

Each member enrolled in HCTC-Basic Health will share the cost for his or her health care coverage. See the sections "Member costs," "If you receive a bill for covered services," and "If a third party is responsible for your injury or illness" on page 24 for details.

Continuation rights

If you leave Basic Health and apply for private insurance coverage in Washington State, your HCTC-Basic Health enrollment will not exempt you from the health plan's use of the standard health questionnaire for screening applicants.

Schedule of benefits

The Schedule of Benefits in Appendix A applies to HCTC-Basic Health members, except as noted in "Covered Services" on the this page.

HCTC contact information

Customer Contact Center (toll-free):
1-866-628-4282 (TTY: 1-866-626-4282)

Website: **www.irs.gov** (IRS keyword: HCTC)

Appendix B-1:
American Indian/Alaska Natives

AI/AN Program Overview

Basic Health members who are enrolled through a Tribal Sponsor that is contracted with Basic Health may receive Basic Health benefits without having to pay member premiums, copayment, deductibles, or coinsurance.

Eligibility

To be eligible for the AI/AN program, you must:

- Be eligible for Basic Health (see page 2);
- Provide proof of your enrollment in a federally recognized American Indian or Alaska Native tribe. Your Tribal Sponsor will help you provide proof; and
- Meet the following definition of "American Indian" or "Alaska Native:"

  Indian means any individual defined at 25 USC 1603(c), 1603(f), or 1679(b), or who has been determined eligible as an Indian, pursuant to 42 CFR 136.12. This means the individual:

  (1) Is a member of a Federally recognized Indian tribe;

  (2) Resides in an urban center and meets one of the four criteria:

  a. Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

  b. Is an Eskimo or Aleut or other Alaska Native;

  c. Is considered by the Secretary of the Interior to be an Indian for any purpose; or

  d. Is determined to be an Indian under regulations promulgated by the Secretary; or

  (3) Is considered by the Secretary of the Interior to be and Indian for any purpose; or

  (4) Is considered by the Secretary of Health and Human services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

Appendix C: Definitions of Terms

Administrative Hearing

An adjudicative proceeding before an Administrative Law Judge or a Presiding Officer that is governed by Chapter 34.05 RCW, the agency's hearings rules found in Title 388 or 182 WAC, or other law.

Appeal

A formal request for the health plan or Basic Health to review its decision.

American Indian or Alaska Native

A person who meets the definition provided in Appendix B-1.

Basic Health

A health care coverage program administered by the Health Care Authority (HCA).

Basic Health *Plus*

A Health Care Authority (HCA) program for children under age 19 from low-income families. It provides expanded benefits (such as dental and vision care). Eligibility for Basic Health Plus is determined by HCA.

Certificate of coverage

A description of your health care coverage and benefits. This handbook serves as your certificate of coverage.

Coinsurance

A percentage you pay for certain services after you have paid your annual deductible.

Copayment or copay

A set dollar amount you pay when you receive specific services. Copays are not subject to a deductible and do not apply toward your deductible, coinsurance, or out-of-pocket maximum.

Countable Income

The amount of a family's monthly income used to determine Basic Health eligibility. This amount is based on the gross family income, after the appropriate disregards. See Chapter 2.

Department of Social and Health Services (DSHS)

The state agency that administers public assistance programs in Washington State.

Deductible

The amount you pay before your health plan starts to pay for services with coinsurance. The deductible will not apply toward your out-of-pocket maximum.

Dependents

Same as family members.

Disenrollment

Losing Basic Health coverage without the option of reenrolling the following month. This can be due to nonpayment by the due date given in the suspension notice; more than two suspensions in a 12-month period; loss of eligibility; or for failure to abide by any of your responsibilities as a Basic Health member.

Emergency

The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

Enrollment

The process of submitting completed application forms, being determined eligible, and being accepted into Basic Health, Basic Health Plus, or the Maternity Benefits Program.

Explanation of benefits (EOB)

Each health plan is required to send an EOB each time you receive medical services. The EOB is a detailed statement that explains the service(s) you received, the allowed amount for each service, the amount the health plan pays, and the amount you are responsible to pay. The EOB will also track the amount you have paid towards each covered family member's annual deductible and out-of-pocket maximum.

Family members

Family members who should be listed as dependents on your account (whether or not they are enrolling for coverage) include:

- Your spouse living in the same household and not legally separated from you.
- Your child, under age 26, including stepchild, legally adopted child, and a child placed in your home for purposes of adoption or under your legal guardianship.
- Your child under age 26, enrolling for coverage and in your custody under an informal guardianship agreement that is signed by the child's parent(s) and authorizes you to obtain medical care for the child. To request coverage for a child living with you under such an agreement, you must provide a copy of the guardianship agreement and proof that you are providing at least 50 percent of the child's support. If a child is placed in your home under a foster care agreement, DSHS is generally the guardian, so you will not be allowed to list that child.
- Your child, stepchild, legally adopted child, or other legal dependent of any age who is incapable of self-support due to disability. You must provide proof of disability. If the dependent with a disability is not your birth or adopted child, you must also provide proof of legal guardianship.

If you are a Health Coverage Tax Credit eligible enrollee, list all dependents that are eligible for coverage through that program.

Family size

The number of family members eligible to be listed on a Basic Health account. Family size is considered when determining eligibility and premiums.

Formulary

A list of approved prescription drugs developed by each health plan.

Grievance

A written or an oral complaint submitted by or on behalf of a covered person to their health plan or Basic Health.

Health Care Authority (HCA)

The state agency responsible for administering the Basic Health Plan and other state-purchased health programs..

Health Coverage Tax Credit eligible member (or HCTC-Basic Health member)

An individual or qualified dependent enrolled in Basic Health and determined by the federal Department of Treasury to be eligible for the tax credit created by the Trade Act of 2002 (P.L. 107-210).

Health plan

An organization that offers health care coverage and contracts with the HCA to provide your care. You choose your health plan when you join Basic Health.

Hearing

A hearing is when you ask Basic Health to review your case after your plan denied your appeal.

Income

Your and your family's gross income (before deductions).

Income band

Income levels A through H, as listed on page 5. These usually are updated in July of each year. (Look for a notice of the changes in May.) These levels, based on gross monthly income and family size, help determine monthly premiums.

Income guidelines

The guidelines used to determine your eligibility for Basic Health and Basic Health Plus, and your monthly premium payments for Basic Health coverage. These income guidelines change annually. See page 4 for more information.

Inpatient

A patient who is admitted for an overnight or longer stay at a health care facility and is receiving covered services.

Maternity Benefits Program

This Health Care Authority (HCA) program includes all Medicaid benefits, including maternity benefits, maternity support services, and maternity case management. Eligibility for the program is determined by HCA.

Medicare

The federal health benefit program for people who are age 65 and over, and for some people with disabilities. (If you are eligible for free or purchased Medicare coverage, you are not eligible for Basic Health.)

Member

A person enrolled in and receiving health care coverage through Basic Health, Basic Health Plus, or the Maternity Benefits Program.

Non-compliance

Failure to provide documentation or information requested by Basic Health by the due date.

Out-of-pocket maximum

The most coinsurance you will have to pay each year for each covered family member. Only your coinsurance costs apply toward your out-of-pocket maximum. After you have paid the out-of-pocket maximum, you do not have to pay coinsurance costs for the remainder of the calendar year.

Outpatient

A nonhospitalized patient receiving covered services away from a hospital, such as in a physician's office or the patient's own home, or in a hospital outpatient or hospital emergency department or surgical center.

Personal eligibility statement (PES)

The notice Basic Health sends you showing the current status of your account. You will receive a PES when there is a change to your account. This statement may include a bill for additional premiums you must pay as a result of a change.

Pre-existing condition

An illness, injury, or condition for which, in the six months immediately preceding a member's effective date of enrollment in Basic Health:

- Treatment, consultation, or a diagnostic test was recommended for or received by the member;
- Medication was prescribed or recommended for the member; or
- Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care, or treatment.

Premium

Your share of the monthly payment for Basic Health coverage.

Primary care provider (PCP)

Your personal health care provider. Your primary care provider can be a family or general practitioner, internist, pediatrician, or other provider approved by your health plan. To receive benefits, your primary care provider must provide or coordinate your care. If you need to see a specialist, your primary care provider will refer you.

Provider

A health care professional (such as a doctor, nurse, internist, etc.) or facility (such as a hospital, clinic, etc.).

Recertification

Periodic review of your family's income and eligibility. During recertification, you must submit current income and residency documentation to verify your eligibility and/or level of premium subsidy.

Recoupment

When Basic Health bills you for the amount you owe the state because you did not accurately report your income.

Service area

The geographic area served by a health plan that provides coverage for Basic Health members.

Specialist

A provider of specialized medicine, such as a cardiologist or a neurosurgeon.

Student

A person enrolled full time in an accredited secondary school, college, university, technical college, or school of nursing, as determined by the school registrar.

Subscriber

The person on a Basic Health account who is responsible for payment of premiums and other cost sharing, and to whom Basic Health sends all notices and communications. The subscriber may be a Basic Health member or the spouse, parent, or guardian of an enrolled dependent and may or may not be enrolled for coverage.

Subsidy

The portion of the total monthly premium Washington State pays for enrolled Basic Health members.

Suspension of coverage

The process of losing health coverage for one month after a monthly premium has not been paid or has been paid in full after the due date. If your coverage is suspended more than two times in a 12-month period, you will be disenrolled and cannot reenroll for at least 12 months.

Tier

A category of drugs related to the pharmacy benefit. Your cost for prescriptions depends on the category (or tier) the prescription falls within. Tier 1 is the category of prescriptions that costs you the least.

Washington Health Program

A nonsubsidized health care coverage program administered by the Health Care Authority (HCA).

Washington resident

A person physically residing and maintaining a residence in the state of Washington. You must be a Washington resident to be eligible for Basic Health. To be considered a Washington resident, members who are temporarily out of Washington for any reason:

- May be required to prove their intent to return to Washington State; and
- May not be out of Washington State for more than three consecutive calendar months.

Dependent children who are attending school out of state may be considered residents if they are out of state during the school year, as long as their primary residence is in Washington State and they return to Washington State during breaks. Dependent children attending school out of state may be required to provide proof that they pay out-of-state tuition, vote in Washington, and file income taxes using a Washington address.

Your residence may be a home you own or are purchasing or renting, a shelter or other physical location where you are staying in lieu of a home, or another person's home.

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Washington State Health Care Authority
Basic Health
PO Box 42683
Olympia, WA 98504

HCA 22-405 (7/12)

Exhibit C
Service Area Awards
February 7, 2012

Bidder:	Amerigroup	Community Health Plan of Washington	Coordinated Care Corporation	Molina Healthcare of Washington	UnitedHealthcare Community Plan	Number of Successful Bidders
Adams		X	X	X	X	4
Asotin		X	X	X	X	4
Benton		X	X	X	X	4
Chelan		X	X	X	X	4
Clallam			X	X	X	3
Clark			X	X		2
Columbia	X		X	X	X	4
Cowlitz		X	X	X	X	4
Douglas	X	X	X	X	X	5
Ferry		X	X	X	X	4
Franklin		X	X	X	X	4
Garfield	X		X	X	X	4
Grant		X	X	X	X	4
Grays Harbor	X	X	X	X	X	5
Island	X	X	X		X	4
Jefferson	X		X		X	3
King	X	X	X	X	X	5
Kitsap	X	X	X	X	X	5
Kittitas	X	X	X	X	X	5
Klickitat			X		X	2
Lewis	X	X	X	X	X	5
Lincoln			X	X	X	3
Mason	X		X	X	X	4
Okanogan		X	X	X	X	4
Pacific		X	X	X	X	4
Pend Oreille		X	X	X	X	4
Pierce	X	X	X	X	X	5
San Juan	X	X	X	X	X	5
Skagit	X	X	X	X	X	5
Skamania			X	X	X	3
Snohomish	X	X	X	X	X	5
Spokane	X	X	X	X	X	5
Stevens	X	X	X	X	X	5
Thurston	X	X	X	X	X	5
Wahkiakum			X		X	2
Walla Walla	X	X	X	X	X	5
Whatcom	X	X	X	X	X	5
Whitman	X		X	X	X	4
Yakima	X	X	X	X	X	5
Number of Counties Successfully Bid	22	28	39	35	38	162